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Senate

The Senate met at 10 a.m. and was called to order by the President pro tempore (Mr. HATCH).

PRAYER

The PRESIDENT pro tempore. Today's opening prayer will be offered by Dr. Hance Dilbeck, senior pastor of Quail Springs Baptist Church, Oklahoma City, OK.

We are very happy to welcome him here.

The guest Chaplain offered the following prayer:

Let us pray.

O Lord, You made Heaven and Earth and all that dwell therein. We praise You as our Creator. You rule above men and nations as the King of Glory, and we praise You as our King.

Father, we bow before You humbly because we believe that You judge men and nations, and we praise You as our judge, and we delight this morning that Jesus teaches us to call You our Father.

And, Father, we give You thanks for the freedom that we have in this Nation. We thank You for those who fight and serve to protect those freedoms. We thank You for the men and women who serve here in this Chamber. We ask that You give them wisdom, that You guide their decisions.

We pray, Father, that You give us grace as a nation and that You give the men and women in this Senate grace to seek justice and love mercy and to walk humbly with You.

In Christ's Name we pray. Amen.

PLEDGE OF ALLEGIANCE

The President pro tempore led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDING OFFICER (Mr. SASSE). The majority leader is recognized.

HEALTHCARE

Mr. MCCONNELL. Mr. President, one of the Senate's very first acts this Congress was to pass the legislative tools necessary to repeal ObamaCare. We did so because the American people, who had suffered for years under the failures of ObamaCare, were calling out for relief.

Everyone knows about ObamaCare's skyrocketing costs and its plummeting choices. Too often, however, this discussion seems to veer into the abstract. These are not just numbers on a page. These are the lives of real people. These are the men and women we represent, Americans who are hurting, middle-class families who deserve better than ObamaCare's failures. We worked hard to provide them with a better way. We did so in the knowledge that this task would not be easy. We understood it would not come quickly. But we knew it was the right thing to do, so we pushed forward anyway. I believe we must continue to push forward now.

I regret that the effort to repeal and immediately replace the failures of ObamaCare will not be successful. That doesn't mean we should give up. We will now try a different way to bring the American people relief from ObamaCare. I think we owe them at least that much.

In the coming days, the Senate will take up and vote on a repeal of ObamaCare combined with a stable 2-year transition period as we work toward patient-centered healthcare. A majority of the Senate voted to pass the same repeal legislation back in 2015. President Obama vetoed it then; President Trump will sign it now.

I imagine many Democrats were celebrating last night. I hope they consider

what they are celebrating. The American people are hurting, they need relief, and it is regretful that our Democratic colleagues decided early on that they did not want to engage with us seriously in the process to deliver that relief.

But this doesn't have to be the end of the story. Passing the repeal legislation will allow us to accomplish what we need to do on behalf of our people. Our Democratic friends have spoken a lot recently about wanting bipartisan solutions. Passing this legislation will provide the opportunity for Senators of all parties to engage with a fresh start and a new beginning for the American people.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant legislative clerk proceeded to call the roll.

Mr. SCHUMER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

RECOGNITION OF THE MINORITY LEADER

The PRESIDING OFFICER. The Democratic leader is recognized.

HEALTHCARE

Mr. SCHUMER. Mr. President, last night we learned that the current Republican healthcare bill lacks enough support to even reach the floor of the Senate. After numerous delays, false starts, false predictions, and two pulled votes, it should be crystal clear to everyone on the other side of the aisle that the core of the bill is unworkable.

It is time to move on. It is time to start over. Rather than repeating the same failed partisan process yet again, Republicans should work with Democrats on a bill that lowers premiums,

• This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.



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provides long-term stability to the markets, and improves our healthcare system.

I heard the Republican leader this morning say that Democrats “decided early on that they did not want to engage seriously” on healthcare. In the same speech, the Republican leader also admitted that the very first thing the Republican majority did this Congress was to pass reconciliation so they could pass healthcare on a party-line vote—50 needed, no Democrats needed. Early on, the majority leader told Democrats: We don’t need you. We don’t want you.

Respectfully, I take issue with the idea that Democrats didn’t want to engage on healthcare. The majority leader admitted that he decided the matter for us when he locked Democrats out of the process at the outset. At the very beginning of this Congress, President Trump and Leader MCCONNELL said: Don’t come knocking on our door on healthcare. We don’t need you.

Now that their one-party effort has largely failed, we hope they will change their tune.

It seems like many Republicans are ready for a truly bipartisan effort on healthcare, indeed. My friend Senator MCCAIN has urged it quite strongly saying: “The Congress must now return to regular order, hold hearings, [and] receive input from members of both parties.” He said that while recuperating in Arizona. So that is how strongly he feels about it.

Other Republican Senators have made similar comments, but the Republican leader still plans to ignore their advice and instead plans on holding a proxy vote on a straight repeal of our healthcare law first.

Make no mistake about it. Passing repeal without a replacement would be a disaster. Our healthcare system would implode. Millions would lose coverage. Coverage for millions more would be diminished. Our healthcare system would be in such a deep hole that repair would be nearly impossible.

In fact, passing repeal and having it go into effect 2 years later is, in many ways, worse than the Republican healthcare bill that was just rejected by my Republican colleagues. It is as if our healthcare system were a patient who came in and needed some medicine and the Republicans propose surgery. The operation was a failure. Now Republicans are proposing a second surgery that will surely kill the patient. Medicine is needed—bipartisan medicine, not a second surgery.

We urge our Republican colleagues to change their tune. Passing repeal now is not a door to bipartisan solutions, as the majority leader suggested this morning. Rather, it is a disaster. The door to bipartisanship is open right now, not with repeal but with an effort to improve the existing system. The door is open right now. Republican leadership only needs to walk through it, as many Republican Members are urging.

The door is to accept the progress we have made in our healthcare system and work to improve it. The Affordable Care Act isn’t perfect, but repealing all of the good things about the law will create such chaos that there will hardly be anything left to repair.

Republicans don’t need to wreak havoc on our healthcare system first in order to get Democrats to the table. We are ready to sit down right now, if Republicans abandon cuts to Medicaid, abandon huge tax breaks for the wealthy, and agree to go through the regular order—through the committees, with hearings, and onto the floor with time for amendments. That is how we perfect legislation here. That is how it has been done for 200 years.

Almost inevitably, when you try to draft something behind closed doors and do not vet it with the public, it becomes a failure—in this case, a disaster. So again our Republican colleagues don’t need to wreak havoc on our healthcare system first in order to get Democrats to the table. We are ready to sit down right now, again, if Republicans abandon cuts to Medicaid, abandon tax breaks for the wealthy, and agree to go through the regular order. The door to bipartisanship is open right now. Republicans only need to walk through it.

I would remind my Republican friends that the CBO has already scored the idea of a clean repeal bill, and it would be a catastrophe. Listen to what the nonpartisan CBO said. The head of CBO is appointed by the Republican leader of the Senate and the Republican leader of the House. Here is what CBO said about repeal: It would cause 32 million Americans to lose their insurance. Premiums would double, while cutting taxes for households with incomes over a million dollars by over \$50,000 a year. It would end Medicaid expansion with no grace period or option for States that like their Medicaid expansion and want to keep it. In many ways, it is just as cruel, if not crueler, to Medicaid as the TrumpCare bill, but in a different way.

So I would expect that the same Senators who are concerned about the TrumpCare bill’s Medicaid cuts will be equally concerned about what repeal and delay would do to Medicaid. Many of my Republican friends rejected roundly the idea of repeal and delay several months ago at the beginning of the year when President Trump first proposed it and it seemed like that was really what Republicans would do. Here are just some of the names back then who said repeal and then replace later doesn’t work: CASSIDY, ALEXANDER, COLLINS, CORKER, COTTON, HATCH, ISAKSON, MORAN, MCCAIN, MURKOWSKI, PAUL.

Well, I would tell those colleagues and all of the others: The idea hasn’t magically gotten better with age. It is still nothing more than a cut-and-run approach to healthcare that will leave millions of Americans out in the cold and will raise costs on everyone—the

young, the old, the sick, the healthy, working Americans, and middle-class families. Everyone will be hurt but the very, very wealthy.

Every day that Republicans spend on trying to pass their now failed partisan TrumpCare bill, every day they spend cooking up new tricks to bully their Members to get on a healthcare bill is another day wasted, another day that could have been spent working on real improvements to our healthcare system.

Democrats want to work with our colleagues on the Republican side to stabilize the marketplaces and improve the cost and quality of care, and we want to do it via regular order, a process this body has used time and again to produce consensus, bipartisan, historic legislation.

The majority leader said in 2014, in a speech entitled “Restoring the Senate,” “When the Senate is allowed to work the way it was designed to, it arrives at a result acceptable to people all along the political spectrum.” But if it is “an assembly line for one party’s partisan legislative agenda,” it creates “instability and strife” rather than “good stable law.”

I want to repeat that. These are the words of Leader MITCH MCCONNELL. I hope Leader MCCONNELL is listening and remembers these words. He hasn’t for the last 6 months, and it has only led to trouble for him and his Republican colleagues in the Senate. Let me read it again, the 2014 speech, “Restoring the Senate” by MITCH MCCONNELL. “When the Senate is allowed to work the way it was designed to, it arrives at a result acceptable to people all along the political spectrum. But if it’s “an assembly line for one party’s partisan legislative agenda,” it creates “instability and strife” rather than “good stable law.”

Leader MCCONNELL, I couldn’t agree more. It is time to start over on healthcare, abandon the idea of cutting Medicaid to give a tax break to the wealthy, abandon this new repeal and run, and use the regular order to arrive “at a result acceptable to people all along the political spectrum,” as Leader MCCONNELL once said. I dare say it would create a much better result for the American people as well.

Thank you.

I yield the floor.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, the leadership time is reserved.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is closed.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to executive session to resume consideration of the Shanahan nomination, which the clerk will report.

The legislative clerk read the nomination of Patrick M. Shanahan, of Washington, to be Deputy Secretary of Defense.

The PRESIDING OFFICER (Mr. FLAKE). The Senator from New Hampshire.

HEALTHCARE

Mrs. SHAHEEN. Mr. President, the majority leader says that he will move forward this week with a vote on a straight repeal of the Affordable Care Act in its entirety. I don't believe that a majority of Senators are willing to support a reckless leap in the dark, which that vote would mean. It is a vote that would end protections for people with preexisting conditions. It would take healthcare coverage away from tens of millions of Americans and tens of thousands in New Hampshire. It would terminate the Medicaid expansion that has been critical to fighting the opioid epidemic in my State and so many States across this country.

According to the nonpartisan Congressional Budget Office, a straight repeal of the Affordable Care Act would result in more than 32 million people losing their insurance coverage by 2026. Premiums would roughly double in the individual marketplaces. I urge my Republican friends not to go forward with this misguided approach.

The idea that they can repeal the healthcare bill now and give us a new bill in 2 years or whatever period of time is in the bill just doesn't pass the smell test. If we haven't seen an alternative to the Affordable Care Act in the last 7 years, there is no reason to believe that our Republican colleagues are going to be able to produce a bill in 2 years when there is chaos in the marketplaces.

There is a better way forward for the Senate and for our country. During the Fourth of July recess, Majority Leader MCCONNELL said that if he can't secure the votes to repeal the Affordable Care Act, he is prepared to work in a bipartisan way with Democrats on legislation to repair and strengthen the law.

I believe that bipartisanship is the best way to get something done. That is what I tried to do when I was Governor of New Hampshire. I worked closely with our Republican legislature, and we got things done. It should not be a last resort for what we are doing; it should be the first resort. It should be what we do to build a foundation for policy in this country.

I am hopeful that following the floor consideration of whatever the majority leader decides to do on healthcare—and, hopefully, it is going to get defeated—we will move forward with the majority leader's fallback plan, which I

believe should be the starting position. We need to start fresh with regular order to craft bipartisan legislation that builds on the strengths of the Affordable Care Act, that builds on what is working and fixes what is not working. As we have been hearing at town-halls and in countless messages from our constituents, this is exactly what the American people want us to do.

There is remarkable consensus in this country that the Republican leaders' bill is the wrong approach. An ABC/Washington Post poll on Sunday found that by a more than 2-to-1 margin, Americans prefer the Affordable Care Act to the Republican leaders' bill. Their bill is strongly opposed by hospital associations, by healthcare providers, by the health insurance industry, and by nearly every patient advocacy group, including the American Cancer Society and the American Heart Association. There is no reason to think that just repealing the Affordable Care Act is going to make that any better.

On Saturday, the New Hampshire Hospital Association, the New Hampshire Medical Society—our physicians—and the New Hampshire AARP joined together in opposition to the bill. They noted that more than 118,000 Granite Staters—nearly 1 in 10 people in New Hampshire—would lose healthcare coverage under the Republican bill, and that number is even greater if we just repeal the Affordable Care Act. Their joint statement urges Senators “to start over and create a new version of legislation that protects coverage for those who have it and provides coverage for those who need it most.”

Mr. President, I ask unanimous consent that the joint statement by these groups be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Concord Monitor, July 15, 2017]

OUR TURN: PROTECTING PATIENTS MUST BE THE FIRST GOAL OF HEALTH CARE LEGISLATION

(By Todd C. Fahey, Stephen Ahnen and James Potter)

The New Hampshire Hospital Association, New Hampshire Medical Society and AARP New Hampshire have joined in opposition to the Better Care Reconciliation Act currently under consideration in the U.S. Senate.

Our three organizations oppose the BCRA because it would erode health protections for millions of Americans and expose them to increased costs and health risks. We believe that any health care legislation should have the goal of protecting patients first.

We are concerned that the BCRA would reduce funding for Medicare by cutting nearly \$59 billion over 10 years from the Hospital Insurance trust fund, which would hasten Medicare's insolvency and diminish the program's ability to pay for services in the future. This would affect hospitals, doctors and consumers by reducing revenue and making it more difficult to provide services to Medicare patients. To put a sharper point on the issue, New Hampshire hospitals are projected to receive approximately \$1.5 billion less in Medicare reimbursements over the next dec-

ade, reductions that were enacted as part of the Affordable Care Act to help pay for the coverage expansions that have occurred. To maintain those spending reductions while millions of people lose health insurance coverage is simply not feasible.

The BCRA threatens protection for people with employer-sponsored health coverage by weakening consumer protections that ban insurance companies from capping how much they will cover annually or over a person's lifetime—leaving people vulnerable to costs that could be financially catastrophic for them.

In addition, the bill cuts more than \$700 billion from Medicaid by creating a capped financing structure in the Medicaid program. This could lead to cuts in provider payments, program eligibility, covered services or all three, ultimately harming some of our nation's most vulnerable citizens and dramatically impacting providers' ability to serve patients and communities who depend on them every day. It has been estimated that this would result in over \$1.4 billion in reduced federal spending on Medicaid in New Hampshire over the next decade. Where would New Hampshire turn to find the resources necessary to care for our most vulnerable citizens?

According to the CBO, the BCRA will leave 22 million more people uninsured, including more than 118,000 Granite State residents who were able to secure vital health coverage through the Affordable Care Act, making it more difficult for our most vulnerable to receive the services they need to stay in their homes. Without health coverage for, and therefore access to, critical health services, patients will seek care in emergency rooms, ultimately raising uncompensated care costs for hospitals throughout New Hampshire and increasing cost-shifting to New Hampshire businesses.

We believe that the Better Care Reconciliation Act needs to be viewed through the eyes of patients and the caregivers who take care of them, and should make protecting health care coverage for our most vulnerable citizens a higher priority. We remain opposed to the BCRA and urge the Senate to start over and create a new version of legislation that protects coverage for those who have it and provides coverage for those who need it most.

We appreciate the efforts of both of our senators to protect access to affordable health care for all Granite Staters, and we urge them to continue to work toward bipartisan solutions that will cover more people, not less, and reduce health care costs, including insurance premiums and the high cost of prescription drugs.

Mrs. SHAHEEN. Mr. President, I strongly agree with these New Hampshire groups. After spending 6 months trying to pass the deeply unpopular, deeply flawed bill to repeal the law, shouldn't we welcome a bipartisan effort to improve the law? I believe the answer to that is yes, and the place to begin is by taking urgent action on a matter where most of us agree, and that is providing certainty to health insurance markets in order to hold down premium increases. In their 2018 rate request filings, insurers say that large increases are necessary because of the uncertainty surrounding the repeal of the Affordable Care Act and because the Trump administration refuses to commit to making cost-sharing reduction payments—those payments that go to insurance companies so they can help their consumers with

the cost of health insurance, making sure that more people can get health insurance. Well, we now have an opportunity to end this uncertainty by putting the repeal behind us and authorizing a simple bill to authorize regular appropriations for the cost-sharing reduction payments.

The current instability in the ACA marketplaces is a manufactured crisis, and Congress can put a stop to it very quickly. That is why I have introduced the Marketplace Certainty Act, which is a bill to permanently appropriate funds to expand the funds for and to expand the cost-sharing repayments. It does two things: It guarantees that these payments are coming, and it is going to cover more people to help. I am pleased to be joined by 26 Senators who have already cosponsored this bill. We can end this artificial crisis. We can immediately restore certainty and stability to the insurance markets, and, in turn, we can get the time we need in order to come together in a bipartisan way to improve this law to build on what is working and to fix what is not.

We have a number of these commonsense measures, and this is one that has been embraced, not just by Democrats but by key Republican leaders, including Chairman LAMAR ALEXANDER and House Ways and Means Chairman KEVIN BRADY, who have urged that these payments be continued. As Chairman BRADY put it, the payments are needed “to help stabilize the [health] insurance market and help lower premiums for Americans.” He added: “Insurers have made clear the lack of certainty is causing 2018 proposed premiums to rise significantly.”

We have heard from our constituents at home. We have heard from doctors, nurses, hospitals, particularly rural hospitals, nursing homes, patient advocates, insurers, and those constituents who were in the statement I asked to be printed in the RECORD. They are pleading with us to set aside our partisan differences and work together to repair the Affordable Care Act.

Again, we know what we can do. It is not just the Marketplace Certainty Act; there are other bills that have been introduced that can fix the uncertainty in the markets and allow us to address other issues with the law.

Bipartisanship should be the Senate's first resort, not the last resort. An excellent place to start is by coming together right now to permanently appropriate funds for the cost-sharing reduction payments that keep health coverage affordable and to look at some of the other commonsense measures that are going to be talked about by my colleagues, like Senator KLOBUCHAR, who will be coming to the floor. She has legislation that would help us deal with the high cost of prescription drugs, which is one of the things that is driving the increasing costs of healthcare. We need to pass these commonsense measures, and we need to do it now.

Thank you.

I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota.

Ms. KLOBUCHAR. Mr. President, I want to thank Senator SHAHEEN for her leadership, and I am proud to be one of the cosponsors of her bill with her commonsense approach—which I believe is the one that will rule the day—to work together on changes to the Affordable Care Act that will help the American people.

I join my colleagues on the floor in sharing the concerns I have heard from so many people in my State and across the country about the bill that has been introduced by our colleagues. I also heard their desire to have us work together to bring down the costs of healthcare and to make fixes to the Affordable Care Act.

Healthcare leaders in my State have come out strongly against the bill released last week because it would be devastating to the people of our State, especially in our rural areas—rural hospitals—and especially to our seniors who rely on Medicaid funding for nursing homes and assisted living.

Last night we heard that we will not be proceeding to that bill, and, instead, the majority leader wants to bring up repealing big parts of the Affordable Care Act without a replacement. I just want to remind my colleagues that the Congressional Budget Office has already looked at this repeal without a replacement, and it is just as bad. Instead of 22 million people losing their insurance by 2026, the CBO has estimated that about 32 million would lose insurance under the repeal approach, and premiums would double. So this repeal effort doesn't help the host of Minnesotans who, according to the Minnesota Medical Association, would be harmed by what they call draconian Medicaid cuts.

It doesn't help our children's hospitals. I met with several last week, and they were very concerned that Medicaid cuts would wreck their ability to provide healthcare to our kids. This was something, by the way, that I heard repeatedly on the Fourth of July. During the parades, people would come out of the blue, out from the sides of the streets, mixed in with the hot dogs and American flags, and there were these families—predominantly families with kids with disabilities—and they would bring children over to meet me and would say how important this Medicaid funding is for their entire family. I remember that once, when the mom brought her child over with Down syndrome, all of the people on the parade route, on that block, cheered for that family.

We know that we are all in this together, and we know that what happens to one family could, next year, happen to another family. You can have a child with a disability. You can suddenly have a disease that could be debilitating to your family's finances. Basically, we never know what is going

to happen to our health or to the health of our family members. That is why we have health insurance, and we must make sure that it is affordable.

In addition to that, we have had the CEOs of our healthcare system stand up and say that these approaches would lead to major job losses in our State. As I mentioned before, for seniors, AARP has said that, in my State, nearly half of all of the adults who receive tax credits under the Affordable Care Act are 50- to 64-year-olds and these subsidies would be eliminated under the repeal bill. This could make healthcare unaffordable, especially for the more than 350,000 people in my State who are aged 50 to 64 who have preexisting conditions.

Now, it does not have to be this way, as Senator SHAHEEN has so articulately pointed out. I know that several of my Republican colleagues have said that they cannot support legislation that would take away insurance for tens of millions of Americans, and I agree. Instead of making these kinds of draconian cuts and moving backward, I think we have to move forward to actually help make healthcare in America better and more affordable.

We can and we should make changes to the Affordable Care Act. The day it passed, I said this is the beginning and not the end. You simply cannot have a major piece of legislation like that and go for years without any significant changes. That is just not how it has worked with major legislation in the past, but every time we have tried to make changes, we have heard back that we have to repeal it. Maybe the result of all of this chaos in the last month has been that people have finally come to realize what the American people want, as Senator SHAHEEN has pointed out, as well as what is the best policy, and that is to make changes.

I support Senator SHAHEEN's Marketplace Certainty Act because it would stabilize the individual market and protect and expand the vital program that reduces out-of-pocket healthcare costs for consumers. I also support the bill of Senator KAINE of Virginia, who is here with us today, and Senator CARPER, which is the Individual Health Insurance Marketplace Improvement Act, which reestablishes a Federal reinsurance program. By the way, this idea of reinsurance is something that our Republican legislature in Minnesota just passed on a State basis and is supportive of. So I see these as not just some pie-in-the-sky ideas. I see these ideas as things that we can work on across the aisle.

I just want to end by talking about some of my ideas, many of which have bipartisan support. Again, I throw them in a package of things that we could be working on. I have a bill that would harness the negotiating power of 41 million seniors who are on Medicare in order to bring drug prices down. Right now, by law, Medicare is banned from negotiating prices with all of

those seniors. Think of the better bargain that those seniors could get if their marketing power were unleashed.

Senator MCCAIN, the Presiding Officer's colleague, and I have a bill to allow Americans to bring in safe, less expensive drugs from Canada, which is, by the way, very similar to the American market. As I have often noted, we can see Canada from our porch in Minnesota. We see right across the border the kinds of prices they are able to get. Senator MCCAIN and I and several Republicans voted for a similar measure, and we think we should be allowed to bring in less expensive drugs from Canada and, perhaps, from other countries. You could also tie to it a trigger, if there is no competition or if prices have ballooned like they have for 4 of the top 10 selling drugs in this country.

Senator LEE and I have a bill that would allow for the importation of safe drugs from other countries when there is not healthy competition.

Senator GRASSLEY and I have a bill to stop something called "pay for delay," which is when big pharmaceutical companies pay off generics in order to keep their products off the market. It would be \$3 billion in savings for the U.S. Government by just passing that, and I would challenge my colleagues to vote against something as simple as that.

Lastly is the CREATES Act, and Senators GRASSLEY, LEAHY, FEINSTEIN, LEE, and I have that bill, which makes sure that we get the samples so that we can get generics on the market, create more competition, and bring prices down.

This debate is about the patients of a nurse practitioner who provides psychiatric care in my State.

She wrote to me:

Please, please, do all you can to prevent these people from losing the health insurance coverage for medical and mental healthcare that is so vital to their lives.

In Minnesota, one-third—32 percent—of the funding for our State's mental health agencies comes from Medicaid, and across the country, Medicaid expansion has helped 1.3 million people receive treatment for mental health and substance abuse issues.

This debate is about the mom in Minnesota who has private insurance and who has colon cancer. She is working full time, raising two school-age boys and going to chemo every single week. She said she fears she will not be able to afford the care she needs to stay alive.

This debate is about the rural constituents whom I noted come up to me at parades, like the Fourth of July, at nearly every other block, and tell me their stories of how they are concerned about their kids with disabilities and how they are concerned for their rural hospitals.

We have things we can do to make this better, and now is the time when we must get them done. We have bipartisan support for these changes to the Affordable Care Act. Let's work to-

gether on them across the aisle, and let's remember that this is about one team, one country. We can get this done.

I yield the floor.

The PRESIDING OFFICER. The Senator from Virginia.

Mr. Kaine. Mr. President, I also take to the floor to talk about healthcare. I appreciate my colleagues who are here, earnestly pleading with all of our colleagues to be about a process—Democrats and Republicans and the committee process that we have in the Senate—that does the work that we are supposed to be doing, which is listening to the American public and improving our healthcare system.

Let me tell you about my first meeting of the day. It was an amazing one. I had a mom, Rebecca, and her 5-year-old daughter, Charlie, in my office. They had asked for the opportunity to meet with me to talk about healthcare. Here is their story.

Charlie is just about 5 years old. She starts kindergarten in the Charlottesville public schools in September. She was born at 26 weeks, or about 14 weeks early. She weighed 1 pound and 11 ounces at birth. She went through the NICU and had great care. When she was released to go home, the doctors thought she would be fine, but within a couple of months, it was pretty clear that she had some significant challenges as she has the diagnosis of cerebral palsy, and she gets 80 percent of her food through a feeding tube. This family has many, many needs.

Charlie, from a cognitive standpoint, is very, very sharp and is excited about starting school, but she has significant needs. Her mother Rebecca said that Charlie is like the case study for why a repeal of the ACA would be a disaster. Charlie has a preexisting condition because of the CP and her challenges. Charlie has already hit all of the lifetime caps that would have rendered her unable to get insurance pre-ACA.

In the hospital, because of her dramatically low birth weight, Charlie was the recipient of Medicaid funds that would be cut under the current bill. Charlie is currently the recipient of a Medicaid waiver, which will help her afford supplies for her feeding tube. When she starts kindergarten in the Charlottesville public schools, Charlie will be given an individualized education plan under the Individuals with Disabilities Education Act, and some of those expenses are being compensated by Medicaid.

The preexisting condition, lifetime caps, and Medicaid cuts all affect this dynamic, young 5-year-old, who is as entitled as any of us to try to be all she can be. If we persist on the path that we are on now with regard to the bill that is being proposed, we will hurt families like these, and we do not need to do that. Instead, we can help them.

Before the passage of the Affordable Care Act, we know that Americans, like Charlie, who had preexisting conditions faced unfair barriers to access-

ing health coverage. There are challenges that we need to fix, but let's celebrate a few things. Since 2010, the rate of uninsured Americans has declined to a historic low. More than 20 million people have gained access and have healthcare coverage—many for the first time in their lives. Another statistic that is interesting is that the number of bankruptcies in our Nation has been cut in half. Pre-ACA, medical costs had driven up bankruptcies, but the ACA has brought the bankruptcy rate down. We have to move forward to make healthcare stronger, not to destroy it.

The Republican bill that is being discussed right now, because of its reductions of coverage, slashing Medicaid, and increases to premiums for seniors, would make the matter worse. The proposed amendment by the Senators from Texas and Utah has led insurance companies to come out and say that this will create a two-tiered system that will punish those with preexisting conditions. The latest plan, which was discussed this morning by the majority leader, would just be a straight repeal of the Affordable Care Act with a promise that we would fix it in a couple of years. It has been scored by the CBO, and the CBO says that it would cause 32 million Americans to lose their coverage and would dramatically increase premiums. Yet we do need to find improvements, and we should be working on that together.

There have been some actions taken by this administration that have compounded challenges. In January, the President signed an Executive order that directed relevant agencies not to enforce key elements of the Affordable Care Act. They terminated components of outreach and enrollment spending. The administration has also threatened to end cost-sharing reduction payments. These actions and additional inactions have created such uncertainty in the individual marketplace that rates have been unstable, and, in some areas, companies are not writing individual policies. The amendment I discussed earlier, from the Senators from Texas and Utah, would make these problems even worse.

There is a better way. There is a way forward, and I am here to just briefly reference a bill that Senator CARPER and I have put on the table that we think will do a good job and should have strong bipartisan support. It is the Individual Health Insurance Marketplace Improvement Act.

One of the ways to address uncertainty in the individual market is to establish a permanent reinsurance program that will stabilize premiums and will give insurance companies some stability so that they can stay in markets, but it will also enable those companies to write premiums at an average level and not have to take into account the high-cost claims. We think it could reduce premiums dramatically all over the country.

Now, the idea of reinsurance should not be controversial. We use it in other

programs—flood insurance, crop insurance, and Medicare Part D. A key part of Medicare that was achieved under the Bush administration includes a reinsurance provision. The Affordable Care Act had a reinsurance in its first 3 years, but it expired. That reinsurance helped to maintain stable premiums. This is an idea that is not a Democratic idea. It is an idea that is tested.

Senator CARPER and I introduced the bill to the Senators on the Finance Committee. I am on the HELP Committee. We are just waiting for the opportunity to be able to present it and get a hearing for it. We ought to be able to work together on reinsurance, on the cost-sharing guarantees that Senator SHAHEEN has proposed, and on a variety of other ideas. Senators CASSIDY and COLLINS have a bill in that uses auto enrollment, which is an interesting concept that we should be tackling.

I am just going to conclude and tell you how naive I am.

I was a mayor and a Governor before I got here to the Senate. When you are a mayor and a Governor, what you know is education and healthcare. We have a Governor here and a Governor here and a Governor here. We have four former Governors who are sitting on the floor. What you know is education, which was your biggest line item, and your second biggest line item is Medicaid—healthcare. I tried to get on the committee when I got to the Senate, and I was not put on the committee. I was very disappointed. For 4 years I tried to get on the HELP Committee. I got on it on January 3. I was so excited. Finally, I am working on something that I know about.

I got a group together of 13 Democratic Senators. Within 48 hours of getting on that committee, on January 5, I wrote a letter to my committee chair, Senator ALEXANDER, a great committee chair, as well as to the Finance chair, Senator HATCH, and to the majority leader, Senator MCCONNELL: If you want to fix healthcare, we are here to sit down with you right now and fix it. I was naive enough to think that, because I was on the HELP Committee, I might be included in a discussion about healthcare. We have had hearings in our committee—many hearings—on nominees, on pensions, on higher ed, on the FDA, but there has been one taboo topic on the HELP Committee since I got on it in January. We are not allowed to have a hearing about healthcare. We haven't had a hearing about the House bill. We haven't had a hearing about Senate proposals. We are being told that we are not going to have a hearing, that we are just going to rush whatever we do to the floor either on a House proposal, a Senate proposal, or a Senate repeal. We are going to completely skip the committee.

Now, you know a little bit about this committee. We have a doctor on the committee, Senator CASSIDY from Lou-

isiana. Our chair of the committee, Senator ALEXANDER, was a Governor. He had a Medicaid Program. He was the president of the University of Tennessee. He had a hospital. He had a medical school. He had physician practice groups. There are people on the HELP Committee who know something about healthcare. There are people on the Finance Committee, which covers Medicaid and Medicare, who know something about healthcare, but we have not been allowed to have a hearing about this. When you have a hearing, you bring people up to the witness table, patients like Charlie, who was in my office this morning, and doctors and hospitals. You ask them what works, what doesn't work, and what can be fixed. We haven't had the opportunity to hear from folks.

So why wouldn't we do exactly what Senator MCCAIN said yesterday? Senator MCCAIN said: We have gone about this the wrong way. We should be the U.S. Senate. We should take advantage of the Senate procedures and the expertise on the Senate committees, including staff expertise, and we should assign these various bills to the relevant committees and have hearings and then come forward with a proposal that will actually improve healthcare for this country.

I am completely confident that if we let the committees do the work they are supposed to do, we will find improvements that can get bipartisan support and that will help Virginians and help Americans. That doesn't seem too much to ask. I hope my colleagues will consider that, and I hope we will be engaged in those discussions soon.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. CARPER. Mr. President, I want to preface my remarks today by asking that you convey to your wingman, Senator JOHN MCCAIN, our colleague, our best wishes and our hope that he is on his way to a speedy recovery and will be back here because we need him. We need his wisdom.

I want to thank TIM KAINE for the leadership that he and Senator SHAHEEN are showing to help us try to stabilize the marketplaces. Senator HASSAN and I have talked a lot about this.

What do we do now? I think this is an opportunity. This is an opportunity here. I realize there is a fair amount of confusion as to which path to take and which way to go. I hope we don't waste this opportunity.

I sent a message to the new chairman of the National Governors Association and to the new vice chairman of the National Governors Association. Brian Sandoval from Nevada is the new chair and the Governor from Nevada, previously the vice chair, and Steve Bullock from Montana is the vice chair. One is a Republican, and the other is a Democrat. I sent them a message this morning saying that it would be good to hear from the Governors. They have been working on a bipartisan letter—

they have been working on it for a while—and this is really the time it could make a positive impact.

We have three people sitting here—four of us—who used to be part of the National Governors Association. I loved it, and I am sure Senator KAINE, Senator HASSAN, and Senator SHAHEEN loved it as well. Here is what I suggested that the Governors may want to consider in their message:

No. 1, urge us to hit the pause button. Hit the pause button. Let's just stop in place for a moment.

No. 2, pivot soon—not in September, not in August, but now, like this week, pivot to stabilizing the exchanges.

No. 3, return to regular order. Senator KAINE has already mentioned this. When I talked with Senator MCCAIN last week a couple of times briefly, we both talked about the need for regular order. People have good ideas on healthcare; introduce them. Committees with jurisdiction, hold hearings. Witnesses, including Governors, should come before the committees of jurisdiction—a couple of committees in the House and in the Senate—and let's hear from the experts, and let's certainly hear from the Governors, who have to run these Medicaid Programs and have a lot of expertise in this area to offer us.

Then I would say, after the August recess, if we can actually do something real in stabilizing the exchanges, what a confidence builder that would be among us and, I think, around the country. It would be a great confidence builder.

The other thing I would mention is that when we come back after the August recess, don't just muck around and wonder what we are going to do; we should pull together in a bipartisan way—something we talked about doing a lot, but we don't often do it—to really do maybe a couple of things.

Let's figure out what we need to fix in the Affordable Care Act. Republicans believe that Democrats feel it is perfect and nothing should be changed. Well, I don't feel that way. My guess is that most of our Democrats don't, either. No bill I have ever worked on was perfect. It can always be done better. The same is true with big programs like Medicare and Social Security, veterans programs, and so on. They can all be done better, and this is certainly the case as well. Let's fix the parts of the ACA that need to be fixed, and let's preserve the parts that ought to be preserved.

I would reiterate, speaking on behalf of some recovering Governors, including me, the Governors need to be heavily involved in this. I suspect that all of the former Governors who are on the floor with me today, when we were part of the NGA, we weren't on the floor—actually, I was on this floor any number of times because Governors had access to the floor—but we had many opportunities, many invitations to testify before Senate committees and House committees on a wide range of

issues. I think we brought value, and we need to hear from them today.

I want to go back and talk about how we go about stabilizing the exchanges. The first thing that would help would be for the administration to stop destabilizing them. That would be a big help.

Senator KAINE has led on legislation—and he has mentioned it, and I want to drill down on it just a little bit—that would provide reinsurance, much as we do in other ways in terms of the Medicare Part D drug program. Using reinsurance is a very common tool, and we can use it to help stabilize the exchanges.

How would it be used in our proposal? If this lady standing right in front of me were getting healthcare and her healthcare needs were expensive, under our reinsurance plan starting in 2018, 2019, 2020, the first \$50,000 in her healthcare that she used in year one, 2018, the Federal Government—well, the insurance companies themselves actually would be on the hook for the first \$50,000 of care she got. Between \$50,000 and \$500,000, under our proposal, the Federal Government would pay for 80 percent of that cost—80 percent of that cost. Between \$50,000 and \$500,000 would be on the Federal Government. Anything above \$500,000 would be back on the insurance company. That is what we would do for the next 3 years.

Starting in 2021 and going forward, the first \$100,000 would be on the insurance company for the costs borne—created by an individual, and then between \$100,000 and \$500,000, 80 percent of that would be on the Federal Government, and after that, the rest of it is back again on the insurance company to pay for.

That is our proposal. We have a bunch of cosponsors on it, and we need some Republican cosponsors as well. It is not a Democratic idea. It is not a Republican idea. It is just a good idea that deserves bipartisan support.

Another thing we ought to do to stabilize the exchanges is what Senator SHAHEEN has proposed; that is, we have these CSRs, cost-sharing reductions. I think of them as subsidies to help subsidize people whose income is under a certain level; I think it is 250 percent of poverty. Folks who are in the exchanges getting healthcare coverage and whose income is under 250 percent of poverty currently receive some subsidies to help buy down and reduce the cost of their copays and their deductibles. It is not really clear whether that is authorized. It is not really clear whether that is being funded, but it has been done for a number of years.

The current administration has been saying: Well, we don't know if we are going to continue to do that.

There have been some States that want to go to court and say: You can't do that.

We need to pass a law and say that we are going to have these cost-sharing reductions and that the subsidies will continue to be offered.

The last thing we need to do is to make clear that the individual mandate or something as good as or at least as effective as the individual mandate is going to be around. For the administration to say: Well, we don't know if we are going to enforce the individual mandate—it just encourages young, healthy people not to get coverage.

We have to make it clear that the individual mandate or something as good as—it could be a proxy for it or maybe several things that work together that could be as effective as the individual mandate. If they don't work, maybe we could just have a default position that would be the individual mandate again.

We ought to have hearings on these kinds of things and discuss them and hear from all kinds of folks.

The other thing I want to mention is just that when I go around my State, my Lord, I have never heard people so interested in encouraging us. I think I am regarded in my State—along with Senator COONS and our Congresswoman, LISA BLUNT ROCHESTER—I think we are regarded as bipartisan people. We are Democrats and proud to be Democrats. We would like to work with Republicans, too, and I think that is part of being a recovering Governor. But on this subject, on healthcare reform, going forward, the people in my State don't want a Democratic victory. They don't want a Republican victory. Frankly, they don't want a Trump victory. They want a victory for our country. That is what they want. They want a victory for our country. And so do I, and I think so do most Democrats in this Chamber and most Republicans.

So let me say again, if I could make this suggestion, let's hit the pause button. Let's stop in place for right now. Let's pivot and figure out how we can stabilize the exchanges. Let's return to regular order. Let's hold bipartisan hearings, have expert witnesses, including folks from all walks of life who know about healthcare coverage, who know a lot about healthcare. After the August recess, let's launch a real, bipartisan effort to fix the things in the ACA that need to be fixed and retain, preserve those aspects that should be retained. As I said before, we need Governors at the table, not just recovering Governors. We need Governors at the table and a bunch of other folks as well who have a lot to contribute.

If we do those things, we will, in the words of—paraphrasing Mark Twain—Mark Twain used to say: When in doubt, tell the truth. You will confound your enemies and delight your friends. I think that is what he used to say. In this case, I would just say, paraphrasing Mark Twain, when in doubt, do what is right. When in doubt, do what is right. We will confound our enemies and delight our friends.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from New Hampshire.

Ms. HASSAN. Mr. President, I am honored to join my colleagues here

today. I thank Senator CARPER for his excellent suggestions and leadership in terms of reaching out to both the current and former Governors as we proceed on this issue. I am very grateful to my colleague Senator KAINE for his leadership on the HELP Committee and what he brings as a former mayor and Governor.

I rise today to join my colleague from New Hampshire in supporting her efforts to help lower healthcare premiums for middle-class Americans and to stabilize the insurance marketplace.

The Trump administration has been working to sabotage the individual market by playing games with cost-sharing reductions. Those cost-sharing reductions help lower out-of-pocket expenses, such as deductibles and copays, for individuals with health insurance plans in the marketplace. This legislation from Senator SHAHEEN is a commonsense measure that would work to prevent the instability and chaos being pushed by the administration.

I also join my colleagues in making clear that we are ready and willing to work across the aisle on priorities that will improve and build on the Affordable Care Act and bring down costs for people in New Hampshire and across the country.

Over the course of the last several months, we have seen that the partisan process Republican leadership has pushed with TrumpCare simply won't work. It is going to take a bipartisan approach in order to make progress, not a senseless repeal bill that would pull the rug out from millions of Americans.

I have seen firsthand that it is possible for Democrats and Republicans to come together in order to improve our healthcare system. As Governor of New Hampshire, I worked across party lines to pass a bipartisan Medicaid expansion plan that delivered quality, affordable insurance to over 50,000 hard-working Granite Staters. Expansion has truly made a difference for communities across my State, particularly for people impacted by the heroin, fentanyl, and opioid crisis.

Just last week, I visited Goodwin Community Health in Somersworth and heard from a woman named Elizabeth. At one point in her life, as a result of a substance use disorder, Elizabeth was homeless, and she lost custody of her son. But Elizabeth is now in recovery, and she works at the SOS Recovery Community Organization in Rochester, helping others get the support they need. She said she owes her recovery to the insurance she has received through the Medicaid expansion and the Affordable Care Act.

Elizabeth's story is a great example of the power of what is possible when we come together on bipartisan solutions to help improve the health of our people. This is the same approach we need to take in the Senate, and I believe there are areas for bipartisan cooperation that we should be working on in order to improve the Affordable Care Act.

In addition to Senator SHAHEEN's legislation to stabilize the individual market and in addition to the legislation we have heard discussed by Senator KAINE and Senator CARPER, there are other things we can do.

I believe it is critical that we take on Big Pharma and bring down the cost of prescription drug prices, including allowing importing safe and affordable drugs and allowing Medicare to negotiate drug prices, and I believe we should eliminate the existing income cliff in the Affordable Care Act which blocks many middle-class individuals from receiving premium assistance.

These are commonsense measures we should be taking now. People across our Nation have made clear, they don't want Congress to do a wholesale repeal of the Affordable Care Act because it would have devastating impacts for them and their families.

I urge my colleagues to put the partisan gamesmanship aside. I join Senator KAINE, as a member of the HELP Committee, in asking for a hearing at the very committee which is supposed to set healthcare policy in this body so we can listen to the voices of constituents, of providers, of other stakeholders. We need to come to the table ready to work on bipartisan solutions in order to improve our healthcare system. All of our people deserve to have access to quality, affordable care so they can be healthy. That makes our country healthy, productive, and strong too.

The PRESIDING OFFICER. The Senator from New Hampshire.

UNANIMOUS CONSENT REQUEST—S. 1462

Mrs. SHAHEEN. Mr. President, I am really pleased to have been joined by my colleagues to talk about the importance of addressing healthcare for all Americans, especially my colleague from New Hampshire. She and I have been touring the State for months now, talking with people in hospitals, with patients, with physicians, with providers, with people with substance use disorders, with providers who are providing treatment for people with substance use disorders, with people all over New Hampshire about what we can do to make sure people get healthcare when they need it.

That should be the goal of this body. It should not be throwing people off their healthcare, which a repeal of the Affordable Care Act would do. It would throw 32 million people off their healthcare.

We can address the instability in the marketplaces. We can do that pretty quickly. Senators KAINE and CARPER talked about reinsurance, something which has worked very well for the first 3 years of the Affordable Care Act, and the reason it doesn't work now is because they have stopped. That is why we are seeing some of these rate increases.

We can address the uncertainty by being clear that we are not going to repeal the Affordable Care Act, by addressing those cost-sharing reduction

payments. The ACA already stipulates that CSR—those payments which reduce the costs of copays and deductibles—are to be made pursuant to 31 U.S.C. 1324.

My bill provides for payments to be made jointly from a permanent appropriation rather than subject to the year-to-year whims of the annual appropriations process. The Marketplace Certainty Act removes all bases for any further questions about what is already clear from a fair reading of the Affordable Care Act as a whole; that both those CSR payments and the advanced premium tax credit subsidies are to be funded from the same permanent appropriation.

I see my colleague from Texas on the floor, and I am sure he is going to object to the unanimous consent request I am going to be proposing in a couple of minutes. He objected last Thursday when I asked for unanimous consent to pass the Marketplace Certainty Act, and he justified the objection by asserting that the cost-sharing reduction payments are—I think he called it a bailout of the insurance companies. That is an inflammatory term, and I think we ought to be careful with how we use it because the truth is, the cost-sharing reduction payments are in no way, shape, or form a bailout. They are orderly payments built into the law to go directly to keep premiums, copays, and deductibles affordable for lower income Americans. In fact, those same payments were included in the bill Majority Leader MCCONNELL just said he is not going to go forward with, the Republican bill. It included those very same cost-sharing reduction payments. I think they were included because there was a recognition that these are important to help address the cost of healthcare for all Americans.

As I said earlier, we have had statements by the chairman of the Health, Education, Labor, and Pensions Committee, LAMAR ALEXANDER, talking about that these payments should be continued. We have heard from House Ways and Means Chairman KEVIN BRADY, who said we need to continue these payments to help stabilize the insurance market. It is the uncertainty that is causing the current problem, and we could address that today—this week—if people were willing to work together.

As Democrats, we have come to the floor to say we want to work together. We think we can address the challenges we face with the Affordable Care Act. We can do it in a bipartisan way. I know we can because TIM SCOTT and I have done it. We passed a bill several years ago by unanimous consent, which basically gave States the ability to control group size for people and for companies in the marketplaces so I know it can be done, and I know we could do it today if there were a willingness on the part of all of our colleagues to work together. That is what the American people want. They don't want 32 million people thrown off their

health insurance. We don't want rural hospitals to close in New Hampshire. We don't want nursing homes to close. We don't want people to be thrown out of their nursing homes.

I was up in northern New Hampshire at a nursing home over the weekend, where I talked to a group of women in their eighties and older. One woman said to me: You know, I worked my whole life. I paid my taxes. I did everything I was supposed to do. I sold my house so I could get into this nursing home so I could qualify under Medicaid. I got rid of all my assets. Now they are telling me I am going to get thrown out? She said: What would I do? I have no place to go. I have no family to help me.

People don't want that. What they want is for us to work together, to help fix healthcare so people can get what they need when they need it.

Mr. President, I ask unanimous consent that the Committee on Health, Education, Labor, and Pensions be discharged from further consideration of S. 1462; that the Senate proceed to its immediate consideration; that the bill be considered read a third time and passed, and the motion to reconsider be considered made and laid upon the table with no intervening action or debate.

The PRESIDING OFFICER. Is there objection?

The Senator from Texas.

Mr. CORNYN. Mr. President, reserving the right to object.

The Senator from New Hampshire has acknowledged that she had made this previous request last week. The Kaiser Family Foundation, among other publications, has clearly stated that the cost-sharing reductions she is asking for are paid directly by the Federal Government to insurance companies. Thus, when I call this an insurance company bailout, I believe that is literally true.

The Congressional Budget Office estimates the cost of these payments at \$7 billion in 2017, \$10 billion in 2018, and \$16 billion by 2027.

So what my friend, the Senator from New Hampshire, is proposing is an insurance company bailout in the tens of billions of dollars with no reform, throwing more money at a broken Affordable Care Act, which has been in existence 7 years now.

I know they would like to blame this on President Trump, who has been in office just a short time—about a half a year—but this is built into the very structure of the Affordable Care Act, and it isn't working.

I, personally, will not be part of any bailout of insurance companies without reforms. That is why we were trying to structure something under the Better Care Act, which unfortunately we haven't been successful with so far. We are going to keep on trying, but this is not the answer.

I object.

The PRESIDING OFFICER. Objection is heard.

Mrs. SHAHEEN. Mr. President, I am disappointed but not surprised that my colleague has objected. I don't believe he objected because of the effort to help pay these subsidies, which are passthroughs to insurance companies.

Reforming how we do those, I am certainly happy to sit down and talk about that, but the fact is, that is not the issue right now. The issue is, this is a way we could address the current uncertainty in the marketplaces in a way that will be good for maintaining stability of healthcare for all Americans. I am disappointed there isn't a willingness to work together to do that.

I hope, as this debate continues, we will finally see people come together to get something done to address, not just healthcare for Americans but to address the one-sixth of the economy that depends on the healthcare industry.

I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. REED. Mr. President, I rise to discuss the nomination of Mr. Patrick Shanahan to serve as the 33rd Deputy Secretary of Defense. The Senate Armed Services Committee held a hearing on his nomination on June 20, and he was voted out of committee by voice vote.

Mr. Shanahan was born and raised in the State of Washington. He received his undergraduate degree from the University of Washington and then a master's degree and MBA from the Massachusetts Institute of Technology. Mr. Shanahan then embarked on a 30-year career at the Boeing Company, where he rose to the most senior echelons of management, working on both the company's defense and commercial programs. Most recently, Mr. Shanahan served as the senior vice president for supply chain & operations.

The Deputy Secretary of Defense is one of the most important positions within the entire national security system. The Deputy serves as the number 2 official at the Department of Defense, as well as the Department's Chief Management Officer. As the second in command to the Secretary of Defense, the Deputy oftentimes is assigned a broad spectrum of responsibilities which require strong management skills.

The Department currently faces challenges on multiple fronts. For more than 16 years, our military has been consumed by two prolonged wars against violent extremist groups like ISIS. As a result, the military has faced a generational fight which has sapped readiness and precluded our military personnel from training for full spectrum operations. However, violent extremist groups are only one of the many challenges facing our country.

The past several years have seen the rise of near-peer competitors, most notably Russia and China. Russia has been a resurgent force bent on disrupting Europe and undercutting our

own Nation and our Presidential election process. China continues its saber-rattling in the Asia-Pacific region by undermining the freedom of navigation and using economic coercion of its smaller, more vulnerable neighbors. When we factor in the destabilizing actions of North Korea and the long shadow of Iran, it becomes urgently clear that we need strong leadership at the Department of Defense. If Mr. Shanahan is confirmed, he will need to contend with all these challenges. It will not be easy and hard decisions on policy and strategy will need to be made.

Perhaps one of the hardest decisions facing the Deputy Secretary of Defense is the allocation of budget resources within the Department. In an ideal world, a cogent defense strategy that takes into consideration the multitude of concerns facing our Nation would inform how the Department invests resources in weapons platforms and advanced technologies to confront these challenges. However, the reality is that the spending caps imposed by the Budget Control Act determine the level of funding for most of these budget decisions.

The current budgetary crisis is compounded by the fact that the President's most recent budget request adds much needed funding to defense activities, but it shortchanges nondefense spending accounts in order to increase spending for our military. Furthermore, the budget request fails to recognize that the BCA budget caps are law. If these spending levels are enacted, the President's budget request would trigger sequestration, effectively wiping out increased defense spending with mandatory across-the-board cuts.

This would be the worst of all worlds. Not only would we be giving the money on the one hand and taking it back with the other hand, but it would not be in any systematic way. We would be making cuts to readiness. We would be making cuts to personnel. We would make cuts to all sorts of things which are much more valuable than some programs which would receive an additional cut.

Unless we resolve ourselves to act—which is going to take a bipartisan effort to repeal the BCA—we can't effectively fund not only the Department of Defense but every other Federal department. That is one of the great challenges Mr. Shanahan will face. Indeed, these multiple challenges will require strong leadership and the ability to make tough decisions. Mr. Shanahan has developed a strong reputation during his tenure at Boeing as someone capable of taking on challenging programs, fixing problems, and turning them into successes.

When I met with Mr. Shanahan to discuss his nomination, he emphasized that the public sector needed to work closer with the private sector to get more cost-effective results while ensuring our warfighters have the best equipment at their disposal. It is that

kind of leadership that the Department of Defense needs as our Nation faces as diverse an array of threats and challenges to our national security as at any point in our history.

Based on Mr. Shanahan's qualifications and experience, as well as his testimony before the Senate Armed Services Committee, I believe he is fully qualified for the job. Therefore, I will vote in favor of his nomination to be the next Deputy Secretary of Defense, and I trust he will do his best to lead the men and women who ably and courageously serve this Nation.

On a final note, if confirmed, Mr. Shanahan will be relieving Bob Work, who has served this Nation ably and selflessly for most of his life. Bob Work served in the U.S. Marine Corps for 27 years, rising to the rank of colonel. In 2009, he was confirmed as Undersecretary of the Navy, where he shepherded the service through many challenges for the next 4 years.

He tried to return to the private sector, but in 2014 he was then nominated and confirmed as Deputy Secretary of Defense. Bob Work was the continuity in the Defense Department through three Secretaries of Defense. He stayed more than 6 months into the new administration in order to aid Secretary Mattis. There is no task, no matter how difficult or how big or small, that Bob Work would not devote all of his energy to until it was resolved. Bob Work personifies his name. He works, tirelessly. Our Nation owes him a great debt of gratitude, and I hope he takes some well-deserved vacation time and enjoys the company of his wife and daughter.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. CRUZ). The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. ALEXANDER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Under the previous order, all time has expired.

The question is, Will the Senate advise and consent to the Shanahan nomination?

Mr. ALEXANDER. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

The bill clerk called the roll.

Mr. CORNYN. The following Senator is necessarily absent: the Senator from Arizona (Mr. MCCAIN).

Further, if present and voting, the Senator from Arizona (Mr. MCCAIN) would have voted "yea".

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 92, nays 7, as follows:

[Rollcall Vote No. 162 Ex.]

YEAS—92

Alexander	Flake	Nelson
Baldwin	Franken	Paul
Barrasso	Gardner	Perdue
Bennet	Graham	Peters
Blumenthal	Grassley	Portman
Blunt	Hassan	Reed
Boozman	Hatch	Risch
Brown	Heinrich	Roberts
Burr	Heitkamp	Rounds
Cantwell	Heller	Rubio
Capito	Hirono	Sasse
Cardin	Hoeven	Schatz
Carper	Inhofe	Schumer
Casey	Isakson	Scott
Cassidy	Johnson	Shaheen
Cochran	Kaine	Shelby
Collins	Kennedy	Stabenow
Coons	King	Strange
Corker	Klobuchar	Sullivan
Cornyn	Lankford	Tester
Cortez Masto	Leahy	Thune
Cotton	Lee	Tillis
Crapo	Manchin	Toomey
Cruz	McCaskill	Udall
Daines	McConnell	Van Hollen
Donnelly	Menendez	Warner
Durbin	Merkley	Whitehouse
Enzi	Moran	Wicker
Ernst	Murkowski	Wyden
Feinstein	Murphy	Murray
Fischer	Murray	Young

NAYS—7

Booker	Harris	Warren
Duckworth	Markley	
Gillibrand	Sanders	

NOT VOTING—1

McCain

The nomination was confirmed.

The PRESIDING OFFICER. Under the previous order, the motion to reconsider is considered made and laid upon the table and the President will be immediately notified of the Senate's action.

EXECUTIVE CALENDAR

The PRESIDING OFFICER. Under the previous order, the Senate will resume consideration of the Bush nomination, which the clerk will report.

The bill clerk read the nomination of John Kenneth Bush, of Kentucky, to be United States Circuit Judge for the Sixth Circuit.

RECESS

The PRESIDING OFFICER. Under the previous order, the Senate stands in recess until 2:15 p.m.

Thereupon, the Senate, at 12:48 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mr. FLAKE).

EXECUTIVE CALENDAR—Continued

The PRESIDING OFFICER (Mr. PORTMAN). The President pro tempore is recognized.

HEALTHCARE

Mr. HATCH. Mr. President, the final pieces of ObamaCare were signed into law a little over 7 years ago. Since that time, Republicans—not just in Congress but throughout the country—have been united in their opposition to the law and our commitment to repeal it. This hasn't been simply a political or partisan endeavor. We are not just

trying to take a notch out of President Obama's "win" column. The simple truth is that ObamaCare is not working.

The law was poorly written, and the system it created was poorly designed. Even a number of ObamaCare supporters have come to acknowledge that it hasn't been working the way it was promised to work. As a result, millions of Americans have suffered astronomical increases in their health insurance premiums and fewer and fewer insurance options to choose from. That is ObamaCare's great irony: The law requires people to buy health insurance while also making it impossible to do so.

For 7½ years, Republicans have fought to expose the failures of ObamaCare and have pledged time and time again to repeal it. Every single Republican Member of the Senate has expressed support for repealing ObamaCare. Most of us have made promises to our constituents to do just that. And those promises, coupled with the obvious failures of ObamaCare, are a big reason why we now find ourselves in control of both Chambers of Congress and the Presidency.

For the last 6 months, Republicans have worked in good faith to find a path forward to both repeal and replace ObamaCare. The released discussion drafts attempted to bridge the divide between our more conservative and moderate Members, so the products were never going to be perfect. Such is the inherent nature of compromise. The draft released last week included additions to address Member priorities and was likely the best chance we had at a compromise bill to repeal and replace ObamaCare with significant entitlement reform. But last night a handful of our Members announced they would not support the compromise bill, even though it would have repealed ObamaCare's taxes, reformed Medicaid by putting it on a sustainable path for future generations, and included the largest pro-life protections on Federal spending I have ever seen.

This was the opportunity we had been working toward. All we had to do was come together and compromise, and 7½ years of promises would have been much, much closer to being fulfilled. But last night we blinked. And, frankly, I think the Members who opted to scuttle the compromise bill will eventually have to explain to their constituents why they left so many ObamaCare fixes on the table and walked away from this historic opportunity.

So where does that leave us? The majority leader has announced his intention to shelve the effort to repeal and replace ObamaCare with a single piece of legislation. Instead, the Senate will move forward to vote on legislation to simply repeal ObamaCare, with a 2-year delay. So, long story short, we have one more chance to do what we have all said we wanted to do.

I am aware that some Members have already expressed their skepticism, if

not their opposition, to this approach. I hope they will take the time to reconsider. As Senators contemplate this path, they should keep in mind that the upcoming vote is not about the next 2 years, nor is it about the past 6 months. We are not going to be voting to approve a specific process for drafting and enacting an ObamaCare replacement, and we are not voting to approve the way this effort has moved forward during this Congress.

I know some of our colleagues have doubts about the path forward. Others have complaints about the path that got us here. But this vote, in my view, will simply be about whether we intend to live up to our promises. Do we want to repeal ObamaCare, or are we fine with leaving it in place? That is the question we have to ask ourselves.

Keep in mind, the vast majority of Republican Senators are already on record having voted 2 years ago in favor of a full ObamaCare repeal with a 2-year delay. Of course, in 2015, we knew that the President would veto that legislation, and we now know that the current occupant of the White House would surely sign it. That is really the only difference between then and now. Was the vote in 2015 just a political stunt? Was it just pure partisanship? I know some of our Democratic colleagues claim that was the case. Were they right? I sure hope not. On the contrary, I sincerely hope that any Member of the Senate who voted for the 2015 bill and who has spent the last 7½ years pledging to repeal ObamaCare hasn't suddenly decided to change his or her position now that the vote has a chance to actually matter.

If we vote to pass a full repeal, will we be solving all of our healthcare problems with a single vote? Certainly not. But that was never going to be the case. Anyone who thought repealing and replacing ObamaCare would be easy once we had the votes was likely not paying attention to the problems plaguing our healthcare system. However, if we act now to pass the full repeal, we will be taking significant steps toward accomplishing our goal and keeping our promises.

If we pass up yet another opportunity, if we can't muster the votes to pass something we have already passed, I have a hard time believing we will get another shot to fulfill our promise and repeal this unworkable law anytime soon. What does that mean? Among other things, it means a congressional bailout of failing insurance markets, probably before the end of 2017. Frankly, that ship may have sailed on that one after last night's developments. We are probably looking at an insurance bailout one way or another. Those who will be interested in moving an insurance bailout later this year should be ready to explain how they want to pay for it.

Failure would also mean premiums will continue to skyrocket and people will be left with few, if any, available insurance options, even though they

will still face penalties if they don't make a purchase. It would mean that the ObamaCare taxes and mandates remain in place, and it would keep Medicaid expansion on the books indefinitely, most certainly creating a scenario for Governors to advocate for the Federal Government to continue paying close to 100 percent of the share for able-bodied adults.

We already know what happens if we leave ObamaCare in place. That scenario is playing out before our very eyes. That downward spiral of broken promises—the one the American people have to deal with every day—is the reason we have all committed to repealing ObamaCare.

Don't get me wrong. I wish the path that got us to this point had been easier, with less melodrama and acrimony. To be honest, I wish we had simply moved to this full repeal strategy at the outset because, as I noted several times earlier in this year, it is probably the most feasible path forward if we want to achieve our goals.

It would be nice if things had gone differently. But this is where we are, with only 52 Republicans in the Senate and a minority that from the beginning has wanted no part of this process.

Right now, we have essentially two choices. We can keep talking about repealing ObamaCare and wishing for a better future, one with more Republican votes or more Democrats willing to acknowledge the reality, or we can press forward with the numbers we have and make good on the commitments we have made to the American people.

To quote the old Scottish nursery rhyme, if wishes were horses, then beggars would ride. Translation: More talking and more wishing will not get us anywhere.

We can either take a significant step forward to undo ObamaCare's mandates and taxes, which have collectively wreaked havoc on our healthcare system, or we can dither about some more and leave them in place for the foreseeable future. In my view, the choice is an easy one.

I urge all of my colleagues to once again vote with me to repeal ObamaCare. We have blown a number of opportunities already in recent weeks. Last night, we blew a big one. I hope we can avoid doing the same with this upcoming vote. If not, we will have to answer to the American people and explain to them why we failed.

I yield the floor.

I suggest the absence of a quorum.

Mr. CARPER. I ask the Senator to withdraw that suggestion, please.

Mr. HATCH. I withdraw it.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. CARPER. Mr. President, good to see you and our friend from Utah. I feel compelled to go back in time, if I could. This is a question a lot of people ask me back home and around the country: Where did ObamaCare come from? The part where most people

think of ObamaCare is when they think of the exchanges that have been established in all 50 States, where people who don't have healthcare can get coverage as part of a large-group plan. That was an idea that came from RomneyCare.

In 2006 in Massachusetts, when Mitt Romney was the Governor and was running for President, they came up with a really smart idea: Governor Romney, you have a much better chance of being elected President if you have done what no other Governor has done; that is, to cover everybody in your State for healthcare.

Well, that is an interesting idea. They looked around for ideas, and what did they come up with? They came up with an idea that was actually suggested by the Heritage Foundation. The Heritage Foundation found its way to this body in 1993 in legislation introduced by Republican Senator John Chafee of Rhode Island that called for doing five things:

No. 1 was creating exchanges or marketplaces in every State, where people who didn't have coverage could be part of a large group and get coverage.

No. 2, folks who bought coverage on the exchange might be eligible for a sliding-scale tax credit. Lower-income people would get a better tax credit, reducing their premiums, than people whose income was higher.

No. 3 was the idea of an individual mandate. People had to get coverage. If they didn't, they would have to pay a fine. You can't force people to get coverage, but in Massachusetts they said: Well, at least we will fine them, and, eventually, maybe over time, the fine will go up and most people—including young, healthy people—will elect to get coverage and be part of a group that is actually insurable, as opposed to people who are just sick or who are anxious to get an operation or are needing to get an operation.

The fourth principle, which was the idea underlying the Chafee legislation, which would later become RomneyCare, was the idea that employers of a certain magnitude, or with a certain number of employees, had to cover their employees.

The fifth principle in that original idea was brought to us from the Heritage Foundation, by 23 Republican Senators in 1993—as an alternative, by the way, to HillaryCare—and later became RomneyCare. The fifth principle was the idea that if you are an insurance company and you want to deny coverage to people because they have a preexisting condition, you cannot do that.

That was it. When a number of us in this body worked on the Affordable Care Act, we took the Heritage Foundation idea, the idea from those 23 Republican Senators who introduced it, cosponsored it—including Senator HATCH, including Senator GRASSLEY. Some of the folks who are complaining the most about ObamaCare or the exchanges are the people who supported

the original legislation introducing the idea. I don't know if that seems ironic to other people. It certainly does to me.

I spent part of Saturday—invited up to Providence, RI, to do something I used to do for 8 years—meeting with the National Governors Association. For 8 years, as Governor of Delaware, I was privileged to be a part of the National Governors Association, at one time vice chair and later on as the chairman of the group. They invited me to come back and talk about healthcare, healthcare reform, and what was going on here in the Senate. I was happy to do that, and we made it work on my schedule.

There, to speak on behalf of the administration, was the Vice President of the country, the Secretary of Health and Human Services, the OMB Director, and the Administrator of the Center for Medicare and Medicaid Services, explaining to the Governors why they should support the administration's position and why they should support the Republican position here in the Senate.

Today the Republicans sent out a strong letter—not just Republicans. Republican Governors and Democratic Governors sent out a joint letter, a bipartisan letter, saying to us, basically: Do these things.

Their advice to us was this: Hit the pause button; stop what we are doing. No. 2, pivot and stabilize. Stop destabilizing the exchanges.

This administration is trying to destabilize the exchanges, which were a Republican idea, and I think, actually, a good idea. But the administration has sought to destabilize the exchanges, through a variety of tricks that they are pulling.

The third thing we should do is to stabilize the exchanges. It is not all that hard. Make it clear that the individual mandate, or something very much like the individual mandate, is going to continue to be the law of the land so that we end up with young, healthy people in the exchanges and not just a lot of sick people and older people.

No. 2 is reinsurance. One of the keys to the success of Medicaid Part D, the drug insurance program for folks on Medicare, is reinsurance. A number of us, led by Senator TIM KAINE and myself and others, said: Why don't we take that tried-and-true idea and use it to help stabilize the exchanges? I spoke here earlier today on how that would actually work. It is not a Democratic or a Republican idea. It is just a good idea.

The third thing we need to do to stabilize the exchanges—an idea actually suggested by a number of Senators, including Senator JEANNE SHAHEEN of New Hampshire—is to say that we are going to continue to fund and authorize something called CSRs, or cost-sharing reductions, which actually reduce the copays and the deductibles for lower income people who buy their coverage in the exchanges.

Those three things, we are told by health insurance companies, would reduce the cost of premiums in all the States by anywhere from 25 percent to 35 percent. It would stabilize the exchanges, and it would get other insurance companies to say: I don't know if I want to insure in Ohio, Delaware, or Utah. Insurance companies would say: Well, I think I can offer insurance products there and not lose my shirt. Then, they would get back into the exchange. They would offer coverage. Then, when more than one or two offer coverage, guess what happens. You have competition. And do you know what flows from competition? Better diversity of products to choose from and lower costs.

Those are three things we can do to stabilize the exchanges and, frankly, they are not all that hard.

The fourth thing the Governors suggested we do is, basically, regular order. Around here, regular order means that if people have a good idea, they introduce it. We turn it in up here at the front desk, and the legislative idea goes to the committee of jurisdiction. There is a discussion of whether there should be hearings about that particular bill. If it is a good bill, there may well be hearings. You have sponsors. It could be bipartisan. But, eventually, the idea will have a hearing in committee, and those who like that idea or those who don't like that idea show up in daylight, in the light of day, and say: Here is why I like it; here is why I don't like it. They let their voices be heard.

On issues as important as healthcare, why we are not fully involving the Governors is beyond me. I just don't get it. Who runs the Medicaid Programs? The Governors in their States. That is a big part of what we are debating in this battle.

I will close with this. I said it before earlier today, and I want to say it again. As I travel around Delaware, talking to people in my little State—we have a lot of Democrats, we have a lot of Republicans, and we have a lot of Independents—they speak to me with one voice, and here is what they say: Work together. Solve some problems together. Democrats and Republicans, take off your hats and work together. That is what they want us to do.

It is not just Delaware. A Kaiser Permanente national survey released last week said 71 percent of the people in this country surveyed said we ought to work together and get this done.

If we are smart, before we leave for the August recess, we will stabilize the exchanges with the three things I talked about. The administration just needs to stand down and just be quiet on this point. If they don't like this Republican idea of the exchanges, just be quiet. But we come back here in September, and we go to work, with regular order, hearings—bipartisan hearings—bipartisan roundtables, and the chance for us to debate legislation in committees in the House and in the

Senate, and on this floor, and to debate amendments. That is the way we ought to do this.

Anytime in this country when we have done really big things—Social Security comes to mind, the GI bill comes to mind, and the 1986 tax reform comes to mind—we didn't do it with just Democratic votes or Republican votes. We did it together. If we do that, we will be stronger together.

I will close with an old African proverb. It goes something like this: If you want to go fast, go alone. If you want to go far, go together.

We need to go far. If we do, we and the American people will get a lot further along toward the three things we have sought ever since Harry Truman was President: No. 1, cover everybody; No. 2, quality healthcare; and No. 3, affordable price. That is the "holy grail," and we should strive to get there together.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant bill clerk proceeded to call the roll.

Mr. CORNYN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. CORNYN. Mr. President, after weeks—make that months, make that years of discussions about the path forward to rescue the American people from ObamaCare, we find ourselves at an important fork in the road.

We have talked among ourselves about the necessity of keeping our promises to repeal and replace ObamaCare. We are coming down to the reality that, without the Democrats being willing to participate in the process and given the strictures of the budget reconciliation process, it is not going to be possible for us to do as much as we would like to do. We will continue to talk, and my hope is that we will continue to make progress with some sort of consensus on how best to proceed.

In the meantime, we do have a bill that 51 Republicans voted for in 2015 to repeal ObamaCare and leave 2 years available for a transition on a bipartisan basis. Here is my concern. Under ObamaCare, there are massive amounts of money being paid to insurance companies for something called cost sharing in order to try to help bring the premiums down, in order to try to help bring the deductibles down to make them affordable. It is pretty clear it is not working, given the 105-percent increase in premiums since 2013 alone under ObamaCare. Right now, we know the individual market, which is the insurance market where individuals and where small businesses buy their health insurance, is in a meltdown mode. That is after 7 years of ObamaCare.

Our friends across the aisle would like to convince you that in the 6 months or so President Trump has

been in office, he has been the cause of that. It is not true.

Many of us, myself included, would love to see us stabilize the individual insurance market while we get some important reforms done to try to help bring premiums down in order to reassure people that we are going to protect preexisting conditions and while we do some additional important work on Medicaid reform.

I would be lying if I said that this is easy. Frankly, people didn't send us here to do easy stuff. They sent us here to do the hard stuff, and we need to continue to use our best efforts to keep our commitments and to deliver something better than the broken status quo of ObamaCare.

My concern is, if we are unsuccessful in doing that—we have already seen, for example, our friend, the distinguished Senator from New Hampshire, propose some additional mandatory cost sharing for insurance companies. According to the Kaiser Foundation, these are direct payments from taxpayers to insurance companies. Rather than working with us to try to make a course correction in ObamaCare and to put it on a sustainable path—our friends across the aisle want none of that. What they want is the cash. They want the billions of dollars that are going to go to insurance companies and no reform.

I personally find that to be an unacceptable alternative. We do need to do something to protect people who are being hurt right now from the sky-high premiums and the deductibles that render their health insurance unaffordable. My concern is, to be absolutely candid with you, right now the President is authorizing on a month-to-month basis the cost-sharing payments, which are sustaining the market as it currently is—not well enough, given the structural problems, but at least keeping some insurance companies available in most places, although not all.

My concern is, unless we pass something like the Better Care Act, we are left with an untenable alternative. The President's statement that he may decide not to make those cost-sharing payments would provoke an immediate crisis in the marketplace, which would force us to act. I don't think that is inherently bad, but I want to make sure that we act in a constructive way, that we are not just throwing billions more dollars at a broken system, but that we actually implement the reforms to put it on the right path.

I know in Washington people tend to think in terms of Republicans and Democrats, and this is all about Obama, this is about Trump, this is about personalities. It is not. It is not even about politics. It shouldn't be, ultimately. This should be about the people we represent in our States and the people we represent across the country. How can we do the best job, given the difficult hand we have been given, to try to help make things better?

This is not going to be the end of the process. This is another step along the journey toward helping to make healthcare more affordable and more accessible.

There is a lot of great work that has been done. As the Presiding Officer knows, he has been at the forefront of trying to make sure we address things like the opioid crisis, which is devastating communities across the country. I was here showing a chart yesterday that the Presiding Officer has seen, showing HIV deaths going way down thanks to modern drugs, car wrecks were still in the 30,000 range, but deaths as a result of overdoses were up around 52,000 a year, I think, is the rough number. That is a public health crisis.

We need to do everything we can to make sure we are delivering services to the people who need it most who are suffering, but if all we do is bail out insurance companies, we will not have done our job, especially toward the communities hurt by the opioid crisis.

We are going to continue to work, but at some point we are going to have to vote, and, yes, people are going to have to be put on record. Now, we are all grownups. Most of us have held political office for a fair time now. We know how to explain our votes to the voters back home, to whom we are accountable.

If you don't vote, then nobody is accountable, and everybody can blame each other for the outcome. I really do worry, unless we redouble our efforts to come up with meaningful reforms to the broken ObamaCare system, that we will be left with an untenable choice, either an insurance company bailout of the same flawed structure of ObamaCare or an immediate crisis that is going to force us to act and do the bailout without any reforms.

Mr. President, the other thing I just want to point out, in the closing minutes I wish to speak, is the process by which our Democratic friends have dragged their heels to the point of almost bringing this place to a halt, particularly when it comes to a new President getting votes on his nominees for Cabinet positions and sub-Cabinet positions. They are the first to criticize the President for not getting things done that he wants to get done, but when they sabotage his ability to try to populate these important positions in the Cabinet and sub-Cabinet positions by dragging their heels on nominations, they are causing a large part of the problem.

To put this in perspective, in 2009, 90 percent of President Obama's confirmations happened by voice vote. That is without a recorded vote, and that is without 30 hours expiring after voting and closing off the debate. This was just essentially an agreement in 90 percent of the cases.

Democrats in the Senate under the Trump administration have allowed only 10 percent of his nominees to be voice-voted. We allowed 90 percent for

President Obama. We didn't agree with President Obama on a lot of things, but we agreed that he won the election, and he was entitled to populate his Cabinet and sub-Cabinet with people of his choice, assuming they weren't disqualified for some other reason.

Well, this week, we have considered Patrick Shanahan, nominated to be Defense Secretary of the Department of Defense, which is a role vitally important to the Department as it works through readiness, modernization, and of course the service to our men and women in uniform, providing them the tools and equipment and the training they need in order to protect the country. In order to accomplish that, the Defense Department needs a full team.

We spend more than \$600 billion a year on national defense, and yet the President can't get his full team put in place on a timely basis because of partisan foot-dragging.

Well, it serves another purpose, I suppose, because the more we are tied up on nominations, the less time we have to deal with legislation. These kinds of tactics remind me of the former majority leader, Harry Reid, whose political schemes cost his party a 60-vote, filibuster-proof majority.

I know the distinguished senior Senator from New York, my friend, the Democratic leader, remembers that when Members of his own party can't bring back home any record of accomplishment for what they have done during their time here in Washington, it is pretty hard to make the case you should be reelected. After Harry Reid blocked participation, not just from the minority but also from the majority so they couldn't go back home and demonstrate that they had fought and accomplished things for their constituents, their party suffered a very tough political price.

So I would urge our colleagues to end this perpetual obstruction on nominations, legislation, and everything else. Noncontroversial nominees should not require days to get confirmed or judges, for that matter, should not require a 30-hour postclosure vote in order to get confirmed by more than 90 votes. That indicates it is not a controversial vote so why burn up the time except out of spite or desire to slow down this administration or this Congress in terms of getting things done.

The American people sorely want leaders at every level of our government. They are hungry for us to lead and to demonstrate we are listening to them and doing what we believe to be in their best interest, and they deserve a Senate that fulfills one of our most fundamental responsibilities, which is to consider and vote on Presidential nominees.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. UDALL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. HOEVEN). Without objection, it is so ordered.

HEALTHCARE

Mr. UDALL. Mr. President, thank you for your recognition.

Let me just say, at the beginning, I thank the Chair for the bipartisanship with which we both work on the Indian Affairs Committee. I very much appreciate that.

We are here with a few Members. I rise with my colleagues from the Senate Committee on Indian Affairs. I think Senator HETTKAMP, Senator FRANKEN, and, maybe, others will join us. I join them in reminding the Congress of its duty to Tribes and in its standing up for the healthcare of American Indians and Alaska Natives across Indian Country.

Most of us are aware of the health disparities facing Native communities. We have seen the news about the failings of the Indian Health Service, and many of us have heard directly from Tribal leaders and Native constituents about the barriers to healthcare access on reservations, pueblos, and in villages, but the Members of the Senate on the Indian Affairs Committee are uniquely aware of the complex ways that the Tribal healthcare system works and how those systems will be catastrophically disrupted by TrumpCare and the repeal of the Affordable Care Act.

The U.S. Government has a trust responsibility to provide American Indians and Alaska Natives with comprehensive, quality healthcare. The U.S. Constitution, treaties, and long-settled legal precedents are the basis for this responsibility. The Indian Health Service is the primary agency for fulfilling this obligation, but our trust responsibilities do not end there. The Medicaid and Medicare Program, Planned Parenthood, and other public health services all play key roles in the delivery of Native healthcare, and because the IHS is so consistently and severely underfunded, the ACA has made a huge difference.

Each fiscal year, the IHS receives a finite allocation of discretionary funding that it must stretch in order to meet the healthcare needs of 2.2 million Native Americans. That leaves the IHS with just over \$3,500 per person—less than one-third of the national average—for healthcare spending. As a result, without additional resources, the IHS is forced to ration care, which limits Native families to hospitals and clinics that can only provide “life and limb” emergency medical services. Basic preventive care, like wellness visits, prenatal exams, and mammograms, have frequently been unavailable to most IHS patients.

“Don't get sick after June,” which is the unofficial motto given to the Indian Health Service on many Indian reservations, has, tragically, become

the epitaph of too many Tribal members whose cancers have grown undetected, whose diabetes have gone untreated, and whose high-risk pregnancies have gone unnoticed. In seeing this catastrophic need for healthcare dollars, Congress enacted a series of laws that supplement IHS's resources. The Affordable Care Act is the most recent and now is the most significant.

Nearly 287,000 American Indians and Alaska Natives from 492 Tribes—almost 90 percent—have benefited from the ACA's Medicaid expansion. Another 30,000 individual Native Americans have private insurance, thanks to the ACA's individual marketplace and the Native cost-sharing subsidies. In my home State of New Mexico alone, Medicaid expansion has insured an additional 45,600 Native Americans. Thanks to the Medicaid expansion and increased access to the individual insurance market, 63 percent of IHS patients have healthcare coverage that allows them to receive care above and beyond the level of life and limb. Because of the ACA, the IHS now receives almost \$1 billion to supplement its healthcare delivery, and that is an increase of 21 percent.

We can see the results. Not only are people healthier, but they are more productive. Health insurance has allowed Native Americans to finish school, return to work, and lead productive lives instead of worrying that their next illnesses could lead to an IHS referral denial or ruin them financially.

It has also improved the economy in Indian Country. The ACA has created new healthcare jobs, and it has led to the construction of new medical facilities. It has meant dialysis clinics on New Mexico pueblos, new hospitals for the Choctaw in Mississippi, and thousands of jobs for Montana's Blackfeet Indian Reservation. These are just a few examples of a nationwide trend.

TrumpCare will undo this progress. It will undo the newly expanded access to care. It will shut down those new healthcare facilities. It will freeze the economic progress of those areas. These are not just numbers and statistics. We are talking about people's lives. Individuals will be harmed by TrumpCare and the evisceration of Medicaid.

Let me tell you about Rachel, Justin, and their two children—Adalie and Jude. They are one Native family whose lives have been changed for the better under the Affordable Care Act and the Medicaid expansion. Rachel and Justin are from the Laguna Pueblo in New Mexico.

Here is a photo of them right after Jude was born in August 2015.

Before the ACA and Medicaid expansion, Rachel received hit-or-miss care from the IHS, but when she enrolled at the University of New Mexico, she was able to qualify for Medicaid because of the expansion. This meant that when Rachel and Justin decided to start a family, Rachel had access to preven-

tive services, including prenatal and maternity care. Rachel was able to get the care she needed when she became pregnant with Adalie. Rachel's prenatal care became even more important when they decided to add to their family when Rachel was in graduate school at UNM. That pregnancy with Jude had serious complications. The doctors figured out that Rachel did not have enough amniotic fluid to support Jude, and she had to have a C-section.

Medicaid expansion allowed Rachel to complete her college education and to get a master's in public administration without her worrying about healthcare for her and her children. Medicaid expansion meant that Rachel was able to get the preventive care she needed to make sure that she and Jude were healthy.

Rachel recently got a job offer to work in her chosen field, but now that she is able to get off Medicaid, she is worried that the Republican healthcare proposals will make insurance coverage ineffective or unaffordable. Even though she lives near her Tribe's IHS facility in the Albuquerque area, she knows that she cannot depend on the IHS to guarantee critical care if insurance premiums become unaffordable. Once again, Rachel is worried about the future of her family's healthcare.

Rachel is one of thousands of Native Americans whose lives have been dramatically helped by the Affordable Care Act and who are scared that TrumpCare will leave them unable to get the healthcare that their families need in the future.

If this bill becomes law, Tribal communities will be forced back to a system of healthcare rationing. If the President and the Republican leadership eviscerate the Medicaid Program and Federal supports for public health programs, Native American lives will be lost. There is no doubt about it. Let me say this plain and simple: TrumpCare would devastate Indian Country, and it must be stopped.

Just this morning, as vice chair of the Indian Affairs Committee, I held a roundtable with Tribal leaders and Native health experts to hear more about how the Republicans' healthcare proposals would impact Tribes. I thank the leaders who came in to talk with me and my colleagues on the committee. Senator FRANKEN, Senator HEITKAMP, Senator TESTER, and Senator CANTWELL were there.

All came to hear these Native leaders, and their insight into the damage this bill could do to Native communities was profound. The Turtle Mountain chairman from North Dakota reported that "don't get sick after June" is no longer true on his reservation because of the ACA and Medicaid expansion. Panelists warned that the rollback of Medicaid would be devastating to Tribal members, and a representative from the San Felipe Pueblo reminded us that Indian health is not an entitlement; it is an obligation.

Now the Republican leader and the President are moving in an even more

dangerous direction. They are pushing to repeal the ACA without having any replacement, which would strip healthcare from over 30 million Americans. It would devastate anyone who is sick today, anyone who relies on insurance one gets through the Medicaid expansion or the Affordable Care Act, and it sets up a disaster for anyone who might get sick after its repeal because it would destabilize insurance markets and would throw our economy into turmoil, killing up to 50,000 jobs in New Mexico alone. As often happens with policies that hurt the most vulnerable, Indian Country would be hit the hardest.

Traditionally, the Senate has worked on a bipartisan basis to address Native American issues. That tradition must continue now. We must work together to find a sustainable solution so that Native Americans can get affordable, quality healthcare when they need it.

Mr. President, I ask unanimous consent that a copy of a letter from the National Congress of American Indians, National Indian Health Board, National Council on Urban Indian Health, and the Self-Governance Communication and Education Tribal Consortium sent to Republican leadership on June 27, 2017, and shared with the Senate Committee on Indian Affairs be printed in the RECORD. This is just one example of the many such letters sent to the Senate over the last few months, and I will submit those additional letters as part of the record at our next Indian Affairs Committee Hearing.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

JUNE 27, 2017.

Re Tribal priorities in Senate healthcare reform legislation.

Hon. MITCH MCCONNELL,
The Capitol,
Washington, DC.

DEAR SENATOR MCCONNELL: On behalf of the National Indian Health Board (NIHB), the National Congress of American Indians (NCAI), National Council on Urban Indian Health (NCUIH), Self-Governance Communication and Education (SGCE), and the Tribal Nations of the United States we serve, we write to convey and explain our strong and united opposition to the Senate's Better Care Reconciliation Act of 2017 (BCRA) in its current form.

While the legislation mirrors several provisions of the House bill that are of critical importance to Indian Country, we have grave concerns about other aspects of the BCRA that make it impossible for us to support the legislation in its current form. Specifically, we cannot support legislation that would gut the Medicaid program or eliminate cost-sharing protections for American Indians and Alaska Natives (AI/ANs). Most importantly, we request that the legislation:

1) Maintain Medicaid funding based on need, rather than capping it according to a complicated per capita allocation formula or through capped block grants.

2) Continue Medicaid Expansion, and at the very least, continue Medicaid Expansion for AI/ANs

3) Protect AVANs from barriers to care that are inconsistent with the federal trust responsibility, such as work requirements under Medicaid

4) Retain cost-sharing protections at Section 1402 of the Patient Protection and Affordable Care Act (ACA); and

5) Maintain funding for preventative services, including the Prevention and Public Health Fund and women's health services.

As you know, the federal government has a trust responsibility, agreed to long ago and reaffirmed many times by all three branches of government, to provide healthcare to Tribes and their members. Both Medicaid and IHS funding are part of the fulfillment of the trust responsibility.

However, the federal government has not done its part to live up to the responsibility to provide adequate health services to AI/ANs. IHS funding is discretionary and is appropriated every year and distributed to IHS and Tribal facilities across the country. But IHS appropriations have been about 50% of need for decades, and Medicaid revenue is essential to help fill the gap. When demand for services is higher than the funds available, services must be prioritized and rationed. As a result of this chronic underfunding, historical trauma, and a federal-state centric public health system, AI/ANs suffer from a wide array of health conditions at levels shockingly higher than other Americans. Nationally, AI/ANs live 4.5 years less than other Americans, but in some states life expectancy is 20 years less. This is not surprising given that in 2016, the IHS per capita expenditures for patient health services were just \$2,834, compared to \$9,990 per person for health care spending nationally. The Senate should pass reform legislation only if it does not reduce access to care for AI/ANs, or further strain the already stretched resources of Indian Health Service, Tribally-operated, and urban Indian health programs (collectively called the "I/T/U").

MEDICAID

Cuts to the Medicaid program outlined in the BCRA are especially troubling. Under a block grant per-capita system, States will experience a dramatic reduction in federal funding for their Medicaid programs. Most will have to either reduce eligibility for the program or reduce or eliminate benefits that are essential to many AI/ANs. Medicaid is a crucial program for the federal government in honoring its trust responsibility to provide healthcare to AI/ANs. Because health care services are guaranteed for AI/ANs, cuts in Medicaid only shift cost over to the IHS, which is already drastically underfunded. Put simply, without supplemental Medicaid resources, the Indian health system will not survive.

AI/ANs are a uniquely vulnerable population and uniquely situated in the Medicaid program. Unlike other Medicaid enrollees, because of the federal trust responsibility, AI/ANs have access to limited IHS services to fall back on at no cost to them. As a result, Medicaid enrollment and utilization incentives are completely different for AI/ANs in Medicaid. Medicaid conditions of eligibility designed to ensure that beneficiaries have "personal investment" do not work when mandatory in Indian country. Instead of participating in these programs, many AI/ANs will simply choose not to enroll in Medicaid and fall back on the underfunded IHS instead. This will deprive Tribal and urban programs of vital Medicaid revenue and strain limited IHS resources to the breaking point.

Medicaid is a crucial program for the federal government to fulfill the trust responsibility. Over 40 years ago, Congress permanently authorized the IHS and Tribal facilities to bill Medicaid for services provided to Medicaid-eligible AI/ANs to supplement inadequate IHS funding and as part of the federal trust responsibility. At the same time,

because Congress recognized that "... it would be unfair and inequitable to burden a State Medicaid program with costs which normally would have been borne by the Indian Health Service," it ensured that States would not have to bear any such costs, by providing that States would be reimbursed at 100 percent Federal Medical Assistance Percentage (FMAP) for services received through IHS and Tribal facilities.

The Senate Finance Committee, which has primary legislative responsibility for the Medicare and Medicaid programs, adopted a similar reimbursement provision as a part of H.R. 3153, the Social Security Amendments of 1973. In its report on the legislation, the Finance Committee justified the 100 percent FMAP by noting:

"... that with respect to matters relating to Indians, the Federal Government has traditionally assumed major responsibility. The Committee wishes to assure that a State's election to participate in the Medicaid program will not result in a lessening of Federal support of health care services for this population group, or that the effect of Medicaid coverage be to shift to States a financial burden previously borne by the Federal Government."

In light of this legislative history, Tribes are pleased to see the 100 percent FMAP preserved in the BCRA. As the Senate considers this proposed legislation, please ensure that this remains in place. In addition, because the federal trust responsibility also follows AI/ANs off of reservations, 100 percent FMAP should also be extended to services provided through urban Indian health programs (UHIPS).

With regard to Medicaid, we respectfully request that the Senate:

1) Continue to Fund Medicaid Based on Need without Caps

Medicaid is an important tool through which the federal government uses to fulfill its trust responsibility to provide for Indian health care.

The cuts proposed by Sections 133 and 134 of the BCRA would be devastating to Tribal and urban health programs. BCRA would make cuts to Medicaid that are even higher than those proposed by the House of Representatives. BCRA's caps are tied to a lower inflation factor beginning in 2025 that would result in even higher cuts to State Medicaid plans.

We were encouraged to see that BCRA contains provisions that would prevent the cost of care provided to AI/ANs from counting against either a per capita cap or a block grant. However, we request that urban Indian health programs be included in the exemption as well. Faced with the cuts proposed in Sections 133 and 134 of the bill, most States will be forced to make cuts to eligibility and/or services in future years. This will affect all providers and recipients, including Tribal/urban providers and AI/AN patients. This will lead to significant cuts in Medicaid revenues for I/T/Us, and will threaten our ability to provide healthcare services to our people. The Indian healthcare delivery system will not succeed if faced with the cuts proposed in BCRA.

To the extent that the Senate bill maintains such dramatic caps, it should work with Tribes to develop a mechanism to exempt reimbursements for services received through IHS/Tribal/Urban facilities from any State-imposed limitations on eligibility or services that may result from these caps. Such reimbursements would be covered by 100 percent FMAP and therefore will not affect State budgets.

We also request language be added to the bill that requires States with one or more Indian Tribes or Tribal health providers to engage in Tribal consultation on a regular and

ongoing basis, and prior to the submission of any Medicaid or CHIP State Plan Amendment, waiver applications, demonstration projects or extensions that may impact them as Medicaid providers or their Tribal members as Medicaid recipients.

2) Preserve Medicaid Expansion

Medicaid Expansion has increased access to care and provided critical third-party revenues to the Indian health system. The uninsured rate for Native Americans has fallen nationally from 24.2% to 15.7% since the enactment of the Affordable Care Act, due in large part to Medicaid Expansion. This has resulted in health care services to AI/AN people who might not have normally received care. It has also resulted in saved revenues to the Medicaid program through preventing more complex and chronic health conditions and saved the Medicaid program money. Medicaid Expansion has increased Medicaid revenues at IHS/Tribal/Urban health programs that are being reinvested back into both the Indian and the larger national health care system.

The BCRA would roll back federal funding Medicaid Expansion by 2024. The Senate should preserve Medicaid Expansion as an option for States on a permanent basis. While BCRA contains important provisions designed to equalize funding between Expansion and non-Expansion States, we are concerned that the funding made available to non-Expansion States is insufficient to match that which has been provided to Expansion States. At the very least, Expansion should be retained for the AI/AN population under a special Medicaid optional eligibility category for State Plans in recognition of the federal trust responsibility.

3) Exempt AI/ANs from Work Requirements

The BCRA would allow the States to impose mandatory work requirements as a condition of Medicaid eligibility, and incentivize States that impose such requirements with a 5 percent increase in FMAP to reimburse them for the administrative costs of implementing such a requirement.

As noted above, mandatory work requirements will not work in Indian country because the incentive structures are completely different. Unlike other Medicaid beneficiaries, AI/ANs have access to IHS services. If work requirements are imposed as a condition of eligibility, many AI/ANs will elect not to enroll in Medicaid. As a result, rather than encouraging job seeking or saving program costs, mandatory work requirements will discourage AI/ANs from enrolling in Medicaid and place pressure on the already underfunded IHS. Further, cash jobs are scarce or non-existent in much of Indian country, making work requirements impossible to meet and job training programs an exercise in futility.

Tribes fully support work programs and employment, but we believe such programs should be voluntary so as not to provide a barrier to access Medicaid for our members. Again, this is consistent with over 40 years of Medicaid policy for Indian Country. To the extent it considers imposing work requirements, the Senate should exempt AI/ANs from any work requirements.

MARKETPLACE

We also ask that the Senate amend the BCRA to maintain cost sharing protections for AI/ANs. These protections were included for AI/ANs in fulfillment of Congress and the United States federal trust responsibility to provide health care to Indians. Section 208 of the BCRA would repeal the cost-sharing subsidy program established by Section 1402 of the ACA. However Section 1402(d) of the ACA also includes important and critical cost sharing protections for AI/ANs who have incomes at or below 300 percent of the federal

poverty level, or who are referred for care through the IHS Purchased/Referred Care (PRC) program. These cost-sharing protections incentivize AI/ANs to sign up for health insurance and also make it affordable. Eliminating them would create a disincentive for AI/AN to sign up for insurance, since they already have access to IHS services. This would result in less third party reimbursements for the Indian health system and have a destabilizing effect on the system's ability to provide health care to AI/AN people. Dollar-for-dollar, leveraging cost sharing protections for AI/ANs and thereby encouraging insurance coverage is a very efficient means of moving the needle forward in meeting the federal trust responsibility for health care resources.

PREVENTION SERVICES

We are also deeply concerned by the proposed reduction of prevention services in the legislation. The elimination of the Prevention and Public Health Fund will cripple Tribes' efforts to support public health initiatives. Many Tribal health programs rely on PPHF directed funding to keep their public health systems operational. Unlike states, Tribes must piece together a patchwork of funds, some of which are derived from the PPHF, to administer basic prevention services. Additionally, the reduction in funding for women's health services around the country will have major impacts on Tribal members, especially those who do not have direct access to services on or near their reservation. The Senate should restore cuts to the preventative services in the legislation.

Tribes support the inclusion of state funding to address the opioid crisis. However, states do not often pass these funds to Tribes. Drug-related deaths among AI/ANs is almost twice that of the general population. To address this problem, Tribes should either receive direct federal funding to address the opioid crisis, or states should be required to engage in state-Tribal consultation on the use of funds appropriated for the states.

In conclusion, the undersigned organizations must oppose the BCRA in its current form. We could support the legislation only if needs-based funding for Medicaid is preserved, Medicaid Expansion is continued, and the other changes outlined above are made to the bill before passage. In fulfillment of the trust responsibility, current exemptions for AI/ANs from health insurance premiums, co-pays, and cost sharing must be preserved, and Medicaid-eligible AI/ANs must be allowed access to the program without further requirements attached to ensure additional burden is not placed on very limited IHS appropriations. Tribes across the country are eager to come to the table to discuss how shortcomings in the current healthcare system can be addressed, without wreaking immeasurable harm on our health programs and the people we serve.

If you have any questions please do not hesitate to contact NIHB's Executive Director Stacy A. Bohlen.

Sincerely,

VINTON HAWLEY,
*Chairperson, National
Indian Health
Board.*

ASHLEY TUOMI,
*President, National
Council on Urban
Indian Health.*

BRIAN CLADOOSBY,
*President, National
Congress of Amer-
ican Indians.*

W. RON ALLEN,
*Board Chairman, Self-
Governance Commu-*

*nication & Edu-
cation Tribal Con-
sortium.*

Mr. UDALL. Thank you, Mr. President.

While this small effort cannot fully replace the necessary government-to-government consultation we owe Tribes on this issue, I hope it reminds us of our Federal obligations to Tribes and to all Native Americans. TrumpCare would turn back the clock. It would violate our trust responsibilities. It would endanger the lives of Native families. We cannot let that happen.

Senator FRANKEN has been such an advocate on the Indian Affairs Committee for Tribes in his State and across the Nation. All of us have worked extensively to try to improve a situation about which, many times, we hear from Tribal members is despairing. I really appreciate his effort and thank him for coming to the floor today and participating in this discussion about Indian healthcare and what these Medicaid expansions mean.

I yield the floor to my colleague and friend from the great State of Minnesota, Senator FRANKEN.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. FRANKEN. Thank you, Mr. President.

I thank my vice chairman of the Indian Affairs Committee, and I thank the Presiding Officer, who chairs the committee. I am honored to serve under both of them.

I rise to discuss the devastating effects the various Republican healthcare proposals that have been made would have on Indian Country.

Republicans are now considering a straight repeal of the Affordable Care Act, with no replacement. This policy, like others that have come before it, would have a devastating effect on Native communities. Today, I want to describe some of the healthcare challenges that these communities face, how the Affordable Care Act has helped to address some of those challenges, and how repealing the Affordable Care Act would undermine these gains and further jeopardize healthcare for an already vulnerable population.

I have served on the Indian Affairs Committee for the past 8 years, and I am continually shocked by what I hear almost every week from Tribal leaders and other witnesses about the challenges that face Native communities. One of the biggest challenges is that the Federal Government consistently falls short of its responsibilities to Indian communities. There is a lack of attention to the concerns of Native communities. There is a dysfunctional bureaucracy and a Congress that doesn't adequately fund Indian programs, and this can create a vicious cycle. When programs don't have adequate funding, they don't work as they should.

Some of my colleagues who have failed to provide Indian Country with

the funding they need point to the resulting program inefficiencies as justification for continuing to cut and underfund critical programs. That just doesn't make sense to me. Healthcare has fallen prey to this vicious cycle even though the Federal Government has a trust responsibility to provide healthcare to Tribes and to their members.

Medicaid and the Indian Health Service are both part of this trust responsibility. Over the years, the Indian Health Service has suffered from lack of resources, poor staffing, and other challenges. The vice chairman was right: "Don't get sick after June" is unfortunately something we hear over and over again, and it is said with some irony but also hurt in Indian Country because the funding runs out then.

These challenges mean that many in Indian Country, particularly those living in remote areas, don't have reliable access to the medical care they need on a timely basis. This is healthcare that was promised by treaty and by our Constitution.

Prior to the ACA, funding shortages meant that IHS was only able to provide people with the most basic services, so a lot of the care that people needed was simply not available. For example, prior to the passage of the Affordable Care Act, the Indian Health Service could not afford to provide vital services, including women's health screenings, like mammograms, or basic diabetes care. If you suffered from diabetes, you often had to wait until dialysis was required or limb amputation was needed before being able to receive care. That is just unconscionable. That is terrible. What is more, American Indians and Alaska Natives were more likely to be uninsured than non-Native populations, which meant that many people who needed care that wasn't covered by the IHS simply went without.

The ACA helped change all of this for the better. First, the ACA gave States the option to expand their Medicaid Programs to include low-income adults without dependent children. Thanks to Medicaid expansion, 11 million Americans, including more than 290,000 American Indians and Alaska Natives, were able to get health insurance. The ACA's Medicaid expansion made it possible for an estimated 60 percent of uninsured American Indians and Alaska Natives to qualify for healthcare coverage.

This expansion, coupled with other Medicaid policy reforms, such as those that simplified the enrollment process, helped increase the total number of people covered under the program. In fact, IHS reported earlier this year that 42 percent of patients receiving services—of those who receive the services—did so because they had coverage through Medicaid. That is what the Indian Health Service said. Forty-two percent of those who received healthcare services did so because they are covered by Medicaid. In Grand Portage, which is a beautiful spot on the

northeastern corner of Minnesota, this meant that well over 20 more band members, many of them children, received coverage. We know from a recent report out of Georgetown University that, nationwide, 54 percent of children in American Indian and Alaska Native families were enrolled in Medicaid in 2015, compared to 39 percent of all children.

This program has been a vital source of coverage, and, with health insurance coverage, people have finally been able to access the healthcare they need. That is what healthcare is really about. Healthcare is about having coverage so that you have routine visits for primary care. So if you are diabetic, you have routine visits. It is not about the emergency heroic event; healthcare is about the constancy of care. That is what improves people's health. That is what improves their lives.

Another way the ACA helped improve healthcare for Native populations was by transitioning the IHS to be the payer of last resort. By establishing that Medicare, Medicaid, and private insurance would be the primary payers, the ACA ensured that there was more money going to provide a wider range of services that people needed, while simultaneously reducing the financial burden on the IHS.

Yet there is more that we need to do to strengthen the Affordable Care Act and improve rates of coverage and access within Native communities. For example, we need to do more to address workforce shortages and lack of competition in insurance markets in rural areas. The Presiding Officer knows that. Also, it is imperative that we tackle the opioid epidemic in Indian Country. But recent Republican efforts to repeal the Affordable Care Act will do nothing to address these outstanding needs and would undermine the recent health and coverage gains Tribal communities have been able to achieve. I know the last bill had money targeted at opioid treatment, but it wasn't anywhere near what will be taken away when the Medicaid expansion and cuts to Medicaid are figured in.

The Republicans' proposals would hurt Indian communities in a number of important ways.

First, they would cause tens of millions of people, including many American Indians and Alaska Natives, to lose coverage, with between 15 million and 18 million Americans losing coverage immediately. For example, Republican plans would end the Medicaid expansion, as I have said, which has been central to providing health coverage to many in Native communities.

Second, they would jeopardize the sustainability and stability of the individual market, while giving huge tax breaks to powerful corporate interests.

Finally, they would increase premiums and reduce subsidies that low-income people receive to help pay for their healthcare, which would put pri-

vate health coverage out of reach for so many.

Efforts to repeal the Affordable Care Act are just bad for Native communities and bad for the country as a whole.

As many of my colleagues know well, American Indians and Alaska Natives are twice as likely, as compared to non-Hispanic Whites, to be overweight, obese, diagnosed with diabetes, and experience hopelessness and depression. In Minnesota, American Indian women are also more likely than Whites to be diagnosed with maternal opiate dependency during pregnancy, and more children are born opioid dependent. Reducing coverage and driving up healthcare costs is the last thing these communities need.

Indian Tribes in Minnesota and in North Dakota and in all of our States are grappling with challenging and complex healthcare needs. They need our help. They don't need legislation that is hastily put together for ideological reasons. They don't need policies that undercut their care and livelihood.

I believe we need to work together across partisan lines. I really hope that is what we are going to do.

The Republican healthcare plans that have been put forward so far break the Federal Government's trust responsibility and undermine the very programs that are helping Indian communities. That is what I sincerely believe.

I urge my colleagues to reject Republican efforts to repeal the Affordable Care Act and instead work with us on a bipartisan basis, in regular order, with hearings before our committees, to strengthen care options for our Native communities and for all Americans. I believe we can do that, and I believe we can work together. It is just the right thing to do.

Thank you, Mr. President.

I yield to the vice chairman of the Indian Affairs Committee, the Senator from New Mexico.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. UDALL. Mr. President, we have been joined by Senator HEITKAMP of North Dakota. I appreciate her work on the subcommittee, her incredibly hard work and hard dedication that she has put in. She has been a champion for her Tribes in North Dakota, a champion for Native children and Native women, and a champion for Native Americans across the country.

I yield to Senator HEITKAMP.

The PRESIDING OFFICER. The Senator from North Dakota.

Ms. HEITKAMP. Mr. President, I think that anyone who picked up the Wall Street Journal over the last couple of weeks and read the stories about Indian health and what is happening, especially in our region of the world in the Great Plains—it shocked the conscience. It should have resulted in a prolonged level of outrage that would bring us all together.

Unfortunately, we have seen this movie one too many times. Things hap-

pen where we see national stories about challenges in Indian Country, about the failure to fulfill commitments under treaty rights. We see despair. We see the incredible rates of poverty, the incredible rates of unemployment, even in a State like ours where unemployment rates are never the issue. We wonder, why isn't something being done? Guess who wasn't shocked. Those of us who serve on the Indian Affairs Committee.

We on the committee spent a lot of time looking at this last year, trying to figure out how we could engage the bureaucracy to be more responsive and more responsible and how we could look at sourcing the dollars we needed to make sure that Indian health was supplemented and that the level of care we expect when we walk into our hospitals—that that is the level of care Native American people who go to the Indian Health Service on their reservations and who might go to an Indian run, a Tribal run facility, would expect. That is what we expect, and I think that is what the American public might think is actually going on, but those of us on the committee know differently.

We held a roundtable today to talk about what those challenges are, what Native American leaders believe are those challenges, and to ask them a simple question: What has Medicaid expansion meant to your Tribes? What does access to Medicare and Medicaid mean for delivery of healthcare services?

I want to start off by saying that they have a lot of great ideas, and I will run through some of these.

Chairman Keplin from Turtle Mountain said: We need local doctors. It is hard to get people to live on the reservation if they are not from the reservation, so we need to figure out how we are going to get local folks to be trained, and we are willing to do that in our Tribal colleges. We need to build relationships with other healthcare providers, like Sanford, that can bring specialists. We need our cancer infusion center to be there so that people can get cancer treatment right at home. And we need to make sure we are doing everything we can to make sure we can treat diabetes right there at home.

So the healthcare challenges were amazing, but the cost challenges were also amazing.

Duane from Pueblo in New Mexico had some very interesting perspectives. Eighty percent of his patient load comes to the clinic. They speak their Native language. They have had stability in their workforce, but they are looking at transitioning to a Tribal facility. But those people don't want to transition because of Federal retirement. So is there something we can do to keep these treasured healthcare providers working for the Tribe and working for their people—the people who know the language and who are familiar with the case studies?

Lincoln from Alaska said: One of our biggest problems is year-to-year funding. The VA has 2-year funding. We don't know what the money is going to be and when it is going to come. We also need to train local people.

Sam said: We have a huge need to continue to build out our cultural resources and our attention to culture and prevention.

Ron from Washington talked a lot about the recruitment of workforce. The employer mandate came up because so much of the employment on the reservations is in fact Tribal members. They are talking about that they are mandated to buy this health insurance, but these same members have a treaty right to that healthcare. Is there a way to help those stretched Tribal resources go a little further by taking a look at some relief from the employer mandate?

The definition of what constitutes an Indian came up over and over.

From Massachusetts, Cheryl talked about permanent reauthorization of Indian healthcare and more resources in diabetes, because that is a pervasive problem, and Indian employment, again, talking about that issue of buying health insurance.

As to marketplace access for Native American enrollees who are not living on the reservation, how do they make sure they are able to get their treaty rights?

Talking about mental well-being and talking about culture is prevention. One of my favorite lines that came out of this was when we asked about prevention, and Ashley said: Culture is prevention. We need better access to 1115 waivers. Take a look at the Canadian model, she suggested. They do more with cultural sensitivity.

The list goes on and on of great ideas. Not one of these ideas said: Repeal the Affordable Care Act. Not one of them said: Let's get rid of Medicaid expansion; let's not look at what we can do.

Let's just all acknowledge what we who serve on this committee know: We have challenges that far exceed many other populations. We have come to the floor to talk about how the repeal of the Affordable Care Act and how the Republican healthcare bill would hurt different populations. We have talked about the elderly. We have talked about children with disabilities. We have talked about rural communities. We have talked about many, many more folks. I think we haven't done enough to talk about what this means for Indian people.

We have a special relationship with Indian people in my State because every Tribe in my State is, in fact, a treaty Tribe with a treaty right to healthcare.

Last night, it obviously became clear that the bill, as it stands, wouldn't get enough votes to move forward. But we need to keep talking about this bill, and we need to keep talking about what the questions are. Instead of talk-

ing about this bill or that bill or all of the acronyms, let's start with healthcare. Let's have a conversation about healthcare that starts with healthcare. Where are we doing it right? Where are we doing it wrong? How can we reduce costs? Who is being left behind?

It is clear to me that in the healthcare world—never mind the Affordable Care Act or the Better Care Act, whatever the Republican bill was called. That is a discussion for politics. That is not a discussion for healthcare. So let's talk about what Native Americans need. Let's talk about how we have failed.

As I said earlier today, Senator UDALL led a really important discussion about how we need to preserve Medicaid. When we look at the Indian Health Service, I think anyone who really looks at the numbers has to admit that it is chronically underfunded.

Last year, I brought the former IHS Director to North Dakota to press her on maintaining quality care in our Tribal communities. This was especially important because of the severe challenges Indian healthcare has. We know that the lack of funding for Indian healthcare can be critically augmented by three main sources: Medicaid, Medicare, and private insurance. If every person walking in has the ability to pay, we are going to improve access to care, and we are going to improve the opportunity to recruit a workforce.

I think some people may roll their eyes when they say: Don't get sick in June. My husband is a family physician and practices about 60 miles north of the Standing Rock Sioux Tribe. He can tell you that there have been times when people from the reservation have come to the clinic to see him because the clinic in Fort Yates is shuttered—no money that day, no opportunity for healthcare. So people come to get the healthcare they need, but they have to drive a long way. It is wrong. You see a new doctor whom you have never seen before and who may not, in fact, understand your condition.

So the Turtle Mountain Band of Chippewa, who are represented today, have over 33,000 enrolled members, of which approximately 14,500 actively receive treatment and benefits for services at the local IHS hospital. Thanks to Medicaid expansion and increased enrollment efforts by the Turtle Mountain Band of Chippewa in my State of North Dakota, their Indian Health Service hospital is now able to offer so much more in services to their people and increase their outreach and prevention.

In June alone, Turtle Mountain's IHS clinic served nearly 13,000 clinical patients and provided over 1,000 emergency room services. Third-party billing revenue has now allowed the Tribes to make renovations to their emergency room and their clinic, to purchase new medical equipment, includ-

ing neonatal monitors, to recruit and hire additional staff, including licensed professionals, to increase staff training and education, to provide Wi-Fi throughout the hospital, and to expand their behavioral healthcare facility to serve more patients.

Since the Medicaid expansion, they have had a 9-percent increase in the number of individuals they have served. Their hospital is also experiencing a decrease in the number of uninsured patients—still too high, in my opinion, at 39 percent. We can get that lower if we get more people to take advantage of Medicaid expansion.

But, unfortunately, a Republican healthcare plan that would eliminate cost-sharing subsidies is making that private health insurance less affordable and less successful.

So let's be honest about how we are affecting our Native American population and talk about the multiple times this expansion has been so important to our Native families.

In North Dakota, the Republican bill would cause an estimated 984 Native Americans to lose cost-sharing reduction subsidies. The Senate Republican healthcare bill would also get rid of the Medicaid expansion and cap the amount of Federal funding States can get to cover those on traditional Medicaid. As a result, it would drastically reduce the amount of Medicaid funding going to the States. This would push the remaining costs to the States and counties that can't afford it.

The American Hospital Association estimates that North Dakota Medicaid would lose \$1.2 billion. I will say that again. North Dakota Medicaid would lose \$1.2 billion through 2026.

Right now, 9,000 North Dakota children and individuals with disabilities—Native Americans, seniors, and low-income families—rely on Medicaid for affordable, quality care, but this bill would rip it away in so many wrong ways.

The uninsured rate for Native Americans has fallen nationally from 24 percent to 15 percent, largely due to Medicaid expansion.

We go on and on. Currently, Medicaid accounts for 24 percent of the Indian Health Service workforce. The Senate Republican bill would strip away \$772 billion from Medicaid, and the White House proposes cutting an already underfunded Indian Health Service budget by 6 percent.

We already know that the per-patient cost in the Indian healthcare system is greatly below that of Medicaid reimbursement cost, on average. So if we take away Medicaid reimbursement, we are hurting not only the providers, but we are once again making healthcare less affordable.

This is a crisis. I can't begin to tell the Members of this body what a crisis Indian healthcare is in. We have known it on the committee for many, many years. In fact, Senator Dorgan was the first one to really sound the alarm of the crisis in the Great Plains area,

thinking that a report that was so damaging would result in change. Guess what. It didn't. It didn't result in change. But the one thing we can point to that is a bright shining light has been access to Medicaid dollars. It has given them access to capital expenditure, and it has given them access to workforce. It has given a more consistent way for people who don't live on the reservations to get healthcare.

I have said this many, many times: We need to not go backward; we need to go forward. When people say: We are going to take a step back, we are going to reduce actual appropriations by 6 percent for Indian health, and we are going to eliminate Medicaid expansion, I say: You had better look before you take a step backward because you might be off the cliff. That is how dire it is in Indian Country.

The one thing I am going to conclude with is that for many, many years in healthcare we have not done what we need to do to consult with Tribal people: Here is the facility; this is what we are going to provide. Good luck. One size fits all.

What we need to do and what Medicaid has allowed is that flexibility for Tribes to engage, for Tribal people to engage in what their needs are, and to take a look at those community health models that do dental care, eye care, and mental health and addiction counseling. All of this needs to be wrapped up. When people say there is no hope, there certainly is no hope without help.

There is an old saying: When you have your health, you have everything. I can tell you from personal experience that it is absolutely true. You could be the richest man in the world, but if you don't have good health, your quality of life is not what it could be.

When we look across the indicators of what has happened in Indian health with indigenous people throughout our country, when we know this is our obligation—this is that treaty obligation, the treaty right that has been bargained for—shame on us.

Medicaid can be that bridge. It can be the bridge to better healthcare. That is why it is so critical, Mr. President and my vice chairman, that we be out here speaking for our communities, speaking for these unique groups of folks who depend so much on Medicaid expansion but who also depend on us to do a better job, to be better stewards of that relationship, to be better citizens as it relates to living up to the obligations that our ancestors negotiated.

I ask everybody who hasn't really been exposed to this issue to read the articles in the Wall Street Journal. But don't just read them and wring your hands and say: This is horrible. Take a step to change the outcome. Don't just read them and say: Boy, that is horrible. Take responsibility for what you read. Every one of us in the Senate and in the Congress is responsible for fulfilling the obligations of these treaties. When we aren't doing it, it is a failure

on every one of us, and it is a failure to protect some of the most vulnerable people in our country—and that is Native American children.

I yield the floor and turn it back to my vice chairman, Senator UDALL.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. UDALL. Mr. President, I know Senator DURBIN is on the floor so I am going to wrap up very quickly. I first want to thank Senator FRANKEN, who came down here and advocated for his State and for Native Americans across the country. I thank Senator HEITKAMP for her passionate speech about Native Americans and Native children. I have known her almost 30 years, as the State attorney general, when she was doing the same things, and she has made real progress.

You can see from this roundtable today—and I really appreciate Senator HEITKAMP coming and helping me chair that. I had to slip out to Foreign Relations, but she spent a significant amount of time chairing that roundtable. I think it really made a difference to all of the Tribal leaders there.

I want to finish with what one of those Tribal leaders said to us.

Senator HEITKAMP, you said something very similar.

This Tribal leader reminded us, he said: Decades ago, Tribes made a downpayment on the healthcare they receive. We are not asking for a handout. We made a downpayment.

What was he talking about?

We made a downpayment with our land, with our water, and with large areas of what were then either territories or the United States—that they considered their homelands. How sad it is to see that we are not fulfilling the promises of these sacred treaties they entered into.

With that, I would conclude—as Senator FRANKEN did and I believe it was the same thrust of what Senator HEITKAMP was saying—with this. We have hit a wall on healthcare. We have come up to the point where you don't know where to go. The best thing to do when you hit a wall is to get back to the regular order, work on a bipartisan basis, go into committee, let people put proposals forward, have amendments, open up the process.

That is where we need to go at this point. I would urge the Republican leadership to take a look at the regular order. That may help us find our way out to improve the healthcare situation for not only Native Americans but all Americans, which is what we face with this TrumpCare, which is taking us in the wrong direction.

With that, I yield the floor.

The PRESIDING OFFICER (Mr. DAINES). The Senator from Illinois.

Mr. DURBIN. Mr. President, let me thank my colleagues for coming to the floor and speaking on behalf of Native Americans and the Indian Health Service, its shortcomings and challenges that it creates for us.

I don't have an Indian reservation in my State, but I certainly have visited these Indian reservations in other States and believe we have an ongoing responsibility—social and moral responsibility—to those who were in this country long before many of our ancestors and who have not been treated fairly many, many times when it comes to the poverty they face in this country and the challenges they face.

It is as bad as or worse than any other group in America. We can do better, and we need to start with the Indian Health Service and health services. I thank my colleagues for raising that issue.

Mr. President, it is interesting, this is a historic week in the Senate because we have been engaged in a debate for weeks about what to do about healthcare in America. The Senate, of course, is under the majority control of the Republicans, as the House of Representatives is, and, of course, with a Republican President. They all came to Washington at the beginning of this year and said: The first thing we want to do is to repeal ObamaCare. We have said it for 6 years. We are finally going to do it. We are going to get rid of ObamaCare, the Affordable Care Act, once and for all.

They set out to do it in a variety of ways. President Trump's first Executive order to the agencies of the Federal Government said: Do everything you can to discourage ObamaCare. He turned around and did just that. His agency stopped advertising for people to sign up for ObamaCare. They were determined to put an end to it.

In the House of Representatives, they took a step beyond that. They introduced legislation to repeal it and replace it. What they replaced it with was a disaster. The Congressional Budget Office took a look at the Republican repeal plan in the House and said 24 million people will lose their health insurance.

Beyond that, they talked about the changes that would take place in health insurance policies with the Republican repeal plan. It passed the House by four votes, which meant that if two Republican Members—and only Republicans voted for it—had voted the other way, it wouldn't have passed. It was that close.

Then it was sent to the Senate, and it was up to the Senate Republicans to decide what they would do with this bill and what they would do with the repeal of ObamaCare. They spent many weeks in conversation and discussion about what they might do. Thirteen Members, Republican Senators, sat in private rooms and talked about what they would do to replace ObamaCare.

Finally, they reported a bill. It turns out their bill was an improvement over the House bill. The House bill eliminated health insurance for 24 million Americans. The Senate bill eliminated health insurance for 23 million Americans. Still, when you look at it, it is a horrible thing.

In my State of Illinois, a million people in my State would have lost health insurance with either the House or Senate Republican bills. It is the reason there has been resistance in my State to this Republican effort from the start.

You would expect it on a political basis. Sure, the Democrats will oppose the Republicans on issues, but this went beyond it. There wasn't a single medical advocacy group in the United States that supported what the Republicans were doing, not one. The hospital associations across America, the medical society of doctors, the nurses, the pediatricians, they all opposed what the Republicans set out to do.

When it looked like there were problems in passing one version of the Senate Republican repeal bill, they sat down to rewrite it. As they sat down to rewrite it, they got into deeper water and bigger problems.

Senator CRUZ, the junior Senator from Texas, said: Well, one way to bring down the cost of health insurance is to take out some of the protections of a health insurance policy. We can get premiums down pretty low if we take away the protections of a health insurance policy that are in the Affordable Care Act.

That was his proposal.

Just this weekend, Blue Cross Blue Shield and the major health insurance industry said that this will be a disaster. If you have some people buying real insurance and real protection and others paying rock-bottom premiums for little or no coverage, you are going to create two classes of Americans, and you are going to see premiums going through the roof for those who are buying full-coverage policies. They came out against the Cruz proposal.

This week, we returned to face the votes. We were supposed to be voting today, a vote on whether to repeal ObamaCare. As of last night, things started changing. Two Republican Senators joined two others and said they were opposing the effort, and so the Republican majority did not have the votes it needed to go forward.

They said: Well, at least we will vote on repealing ObamaCare.

Three Republican Senators have announced, as of today, that voting for simple repeal is something they will not do. Many of them make the argument that just repealing ObamaCare without replacing it is irresponsible. They are right.

If you don't like the current system, I believe you are duty-bound, as a Senator or Congressman, to come up with a better idea, something that serves America better. They have been unable to reach that point.

Where are we? At this moment, we are at a standstill. The Republican efforts to repeal and replace have stopped as of this moment. There may be a vote, an official vote this week. I don't know. That is up to Senator MCCONNELL as the Republican leader, but it appears there is no plan coming

out of the Republican side to replace the Affordable Care Act.

I am proud to have voted for it. I voted for it for very simple reasons. When it comes to health insurance, I believe that is one of the basics in life. I am one of those politicians who believes healthcare is a right, just like police and fire protection. It should be part of who we are in America. I don't believe it is a question of how rich you are or how lucky you are as to whether you have health insurance in this country.

We can do better as a nation. The Affordable Care Act set out to do that. We reduced the number of uninsured Americans with ObamaCare when we passed it 6 years ago by 50 percent. We reduced by half the uninsured people living in my State of Illinois. Many of them went to the insurance exchanges, bought private health insurance. If they had lower incomes, they got subsidies to help pay the premiums. Others picked up Medicaid coverage as their health insurance. It was significant.

I ran into people all across my State, from Chicago to downstate, who had never had health insurance 1 day in their lives. These are not lazy people. These are hard-working people who happen to have the kind of jobs that didn't offer health insurance.

Ray Romanowski, big Polish fellow, guitarist and musician in Chicago said: Senator, I have never had health insurance. I am a musician. Nobody was ever going to provide me with health insurance.

He said: Lucky I have it now because I have been diagnosed with diabetes. I am in my sixties, and I have, through the Affordable Care Act, health insurance through Medicaid.

Similar story, almost identical story in deep Southern Illinois. Judy, who works as a hospitality hostess in a local motel—she is the one who greets you with a smile when you come in for that free breakfast. Judy is 62 years of age. She never had health insurance 1 day in her life. She holds down two and three jobs at a time. The only health insurance she ever had is what she has now under Medicaid.

What is going to happen to those people if we eliminate Medicaid coverage—which the proposals before us suggested—if Medicaid coverage is cut back dramatically?

Those two people, Ray and Judy, are still going to face health challenges. They are still going to get sick and go to the hospital, but if they don't have health insurance, will the hospital treat them? Yes. What will happen to their bills? Their costs will be passed on to everyone else. That is the way it used to be done.

What we have learned this week in Washington, in this national healthcare debate, is there are of course concerns about whether the current healthcare system is what it should be, and I think it can be improved, but we have learned one basic

thing. We are not going back. We are not going back to the days when health insurance companies could deny coverage to you or your family because of a preexisting condition. We are not going back to the days where they put a limit on how much they would pay on your health insurance plan.

Remember when you first realized that a \$100,000 limit was not worth that much if you had a serious diagnosis or a serious accident? We are not going back to the days when that health insurance plan literally expired in coverage, forcing you and your family into bankruptcy over medical bills.

We are not going back to the day when families couldn't cover their kids coming out of college. The Affordable Care Act said you can keep your child on your health insurance plan as a family until they reach the age of 26.

Those of us who have had kids who have graduated college realize they don't always get a great job right off the bat. Some of them start as interns or part-time workers, and they don't have health insurance. They now know they have the peace of mind of the family health insurance plan.

We want to make sure we protect that. We are not going back to the day when those young people had no coverage at a critical moment in their lives. We are not going back to the day when we allow these insurance companies to charge whatever premiums they wish.

We put provisions in the law that limit the premiums that can be charged on Americans, that limit the profits that are taken out of health insurance companies. Those were moves that had to be made to protect innocent American families who, unfortunately, were struggling with medical bills before this law passed and now at least have some chance of paying for them.

What we learned in the course of this national debate is significant. We learned that if you put up a proposal, as the Republicans did in the House and the Senate, that takes health insurance away from over 20 million Americans, you have a problem. People are going to push back and say that it isn't fair to take away health insurance and the protection and peace of mind that come with it. If you come up with a plan that ends up dramatically cutting back on Medicaid, you are going to get a lot of people who are concerned about it.

Across America, the Medicaid Program as we know it does many significant things. One-half of the babies born in my State of Illinois are covered by Medicaid. Mom and her prenatal care, the delivery of the baby, and the caring for mom and the child afterward are covered by Medicaid. If you make a cut in the reimbursement for Medicaid, you will endanger the basic treatment needed to have a healthy baby.

The second thing we know is that Medicaid is critical for people with disabilities. I met a mother in Champagne, IL, and she came up and told me

she has a 23-year-old autistic son. It has been a struggle for her and her family, but now he has a somewhat independent life. She said: Senator, if you take away Medicaid insurance from him, I will have to put him in some institutional program that I cannot afford. There is nowhere to turn.

I also want to remind people that Medicaid pays school districts to take care of kids with special education needs, transportation, counselors, even feeding tubes for the severely disabled. That is an important part of Medicaid.

I haven't touched on the most expensive part of the Medicaid Program in America. The most expensive part is for those who are in nursing homes, those who are older Americans and need Medicaid to get by. They have Social Security and they have Medicare, but they need Medicaid. If you cut back on Medicaid as proposed by the Republicans in both the House and the Senate, who will take care of these elderly folks who are in a situation where they have exhausted their savings? Do they move back in with the family? Sometimes that is not even possible, but that is one of the prospects faced.

What we need to do is to accept the obvious. We have reached an important political milestone here where the Republicans don't have the votes to move forward, but we still have the challenge of the current system. I was proud to vote for it, but it is far from perfect. The current healthcare system in America, the Affordable Care Act, needs help, needs changes. We need to do it. We ought to just surprise the heck out of America by working together, both political parties, to solve the problems.

Let's identify a few of the most obvious problems.

No. 1, the Affordable Care Act in America today does not address the cost of prescription drugs. You ask a health insurance company: What is driving the cost of premiums? Prescription drugs.

Did you ever notice that when you turn on the television at certain times of the day, it is all about drugs? It is all about new drugs, things you can hardly pronounce. These new drugs are being advertised on television time and again. And then there is a 2- or 3-minute disclaimer: Be careful. If you take this drug, you might die. Be sure and tell your doctor if you have ever had a liver transplant.

I listen to all these warnings, and I am thinking, this is being sold in advertising for the general population? Did you know that there are only three countries in the world that allow television advertising of prescription drugs—the United States, New Zealand, and Brazil?

Why do the pharmaceutical companies advertise drugs on television? Certainly if you want to inform a doctor about a new drug, you wouldn't buy a television ad, would you? The reason they are on television is so that we, as

individual consumers and patients, will walk into the doctor's office and say: Doctor, it took me five times, but I finally figured out how to spell "Xarelto," and I want Xarelto as my blood thinner.

The doctor has a choice: He or she can explain to you that you may not need Xarelto, that there is a cheaper version of blood thinner or that this isn't the one that really fits your needs in this circumstance. Doctors don't do that. Many of them just write out the prescription. That is why the television advertising is taking place—to convince the consumer, who asks the doctor and who ends up with the high-priced drug being scripted for them. That is the reality of why the costs of healthcare keep going up.

What does the Affordable Care Act do about that? Nothing. It does nothing when it comes to the cost of prescription drugs. I want these drug companies to make a profit, don't get me wrong. If they are profitable while looking for new cures, that is the way it should be. But when they charge through the roof and double and triple the cost of these pharmaceutical drugs, that is not fair. It is not fair to consumers, and it is not fair to taxpayers.

Think about the fact that many of exactly the same drugs made in the United States are sold in other countries for a fraction of what they cost in the United States. Even in Canada, they charge about one-half or one-third for many of the most popular drugs because the Canadian Government said to the drug companies in America: We are drawing the line. We are not going to let you charge anything you want to charge.

Why don't we do something in America to protect consumers? Why don't we at least inform people when pharmaceutical companies are overcharging so that we can put some pressure on them to stop? That is part of the change to the Affordable Care Act that I think will save us money and at the same time deal with an issue most Americans really are concerned about.

We also should be concerned about the fact that when it comes to the individual health insurance market, that is where most of the problems are. Six percent of the American population buying health insurance through the exchanges—half of them have to pay the full premiums, and some of those premiums go through the roof. Why? Because the people who are buying this insurance are usually people with a medical history or they are older folks and they want to have the peace of mind of coverage. The healthy, younger folks aren't buying it. As a result, the insurance risk pool gets pretty expensive when it comes to premiums. We need to fix that, and we can fix that. That is another thing on which we should come together as Democrats and Republicans to try to achieve.

For those who say: Well, I promised my entire political career that I couldn't wait for the day to come for-

ward and vote to repeal ObamaCare, I just want to tell them that they should be aware that when the Congressional Budget Office looked at the impact of just repealing the Affordable Care Act and not replacing it, they said the following: This would force more insurance companies to leave the market immediately. It would increase premiums by 20 percent a year and double the price of premiums over 10 years, and it would take health insurance away from 32 million people.

So taking that vote to repeal the Affordable Care Act may earn you a cheer at some political rally, but it is not responsible. It is not good. It will raise the cost of health insurance for families across our country if we just repeal and don't replace, and it will take health insurance away from over 30 million people, according to the Congressional Budget Office. It is better that we replace it with something responsible, better that we take the current system and make it stronger.

This has been an interesting debate. I have learned a lot in the course of this debate because I went and visited the hospitals in Illinois. The Illinois Hospital Association opposed the Republican plan in the House and opposed the proposal in the Senate. They said it would cost us 60 to 80,000 jobs in Illinois and it would close down some hospitals we need in rural parts of our State, smalltown hospitals that are critically important. I don't want to see that happen, the people who live there don't want to see that happen, and you won't be able to keep and attract good employers and good jobs if that does happen. So I have worked with these hospital administrators and want to move forward with them on an alternative.

I will close by saying this: It is interesting how many people say "I can't wait until I reach age 65 because I will qualify for Medicare." Medicare doesn't discriminate based on pre-existing conditions and provides good health insurance for millions of Americans. It is an illustration and a lesson for us that if you have something that isn't driven by the profit motive, that people trust, that has provided basic, good care for Americans, good hospitals and good doctors, that is what people are looking for. Why shouldn't they? That should be part of the American dream. It should be part of our right as Americans.

Mr. President, I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. JOHNSON). The clerk will call the roll.

The assistant bill clerk proceeded to call the roll.

Mr. ENZI. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ENZI. Mr. President, in our job, we get a lot of books, probably two or three a week at least, and for the last year most of those have been on

healthcare and healthcare reform. A book I received recently is one called "Demystifying ObamaCare," by David G. Brown, who is a doctor. It was helpful enough to me that I thought I would share a part of it with anybody listening. It always fascinates me when we are here talking and maybe somebody is listening.

Page 7 starts out by talking about, "How Does ObamaCare Look After Seven Years?" Incidentally, this one is all well documented and footnoted, which is one of the unusual things about this book. It is not just speculation on his part—it is a lot of research that he has done and shared. He says:

ObamaCare actually reduces insurance market competition by strict rules, regulations, and mandates.

ObamaCare significantly increases healthcare cost by the way it attempts to assist those who cannot afford coverage.

ObamaCare does not tackle the underlying causes of increased costs. Instead, it worsens the factors that drive up the cost of healthcare with the addition of mandates, regulations, and taxes. ObamaCare does nothing to decrease the factors that increase costs.

ObamaCare has increased the total number of healthcare spending. The cost is not \$938 billion dollars, but now is \$2.6 trillion dollars over 10 years, or almost 3 times the original figure.

ObamaCare increases cost for families, businesses, and individuals for their healthcare. This includes not simply ObamaCare exchanges but health insurance across the board. Associated with this, there has been a marked increase in healthcare premiums, costs for medications, deductibles, and copays.

There has been reduction of access to care in ObamaCare plans, i.e. ObamaCare exchanges (insurance does not equal access).

ObamaCare, to some extent, has reduced the number of uninsured but not handled the problem of the uninsured population.

ObamaCare does not effectively address the problems of the safety net system, i.e. putting new people into Medicaid has exacerbated the problems for Medicaid, and removes its original safety net function.

ObamaCare has reduced funding and thus care for programs for the elderly, Medicare.

ObamaCare has taken the decision making process out of the hands of patients and their families. It has done so by removing their freedom to make those decisions.

This is from the book, "Demystifying ObamaCare," by David Brown, who is a doctor.

It goes on later to say:

The individual mandate was instituted as a way to force patients into having health insurance or else pay a financial penalty for not having it. The employer mandate, which was just instituted in 2016 after several delays, was intended to move those with employer-based insurance into the government sector. Additionally, the HHS required all individual and small group policies to meet the "essential health benefit" requirements. These benefits were determined by the secretary of the HHS and required involvement of not simply government, but also non-government plans. The individual and small group policies then had to be sold at a more significant cost to the consumer.

How is the Employer-Based System changed so employees could be moved into a government system?

Businesses with 50 or more full-time employees had to provide health insurance approved by HHS or be financially penalized.

The cost for businesses for the penalties for not providing insurance was less than the cost of the insurance.

ObamaCare exchanges were there to take in anyone who needed to have insurance. Employer based mandates were a way of moving employees out of the employee-based marketplace into a government program. It is the back door way of having a government based healthcare system. It was ingenious but fortunately, for the American people it was flawed.

Yes, Americans in the individual market lost their insurance (5 million Americans) but the employer-based mandate was postponed through the efforts of Congress. Many of the larger companies have self-insured their employees. The ObamaCare exchange program has been very expensive for the consumers. It has also significantly limited access to care i.e. narrowed networks of providers, (doctors and hospitals). ObamaCare has increased the numbers in Medicaid but this program itself has severe flaws.

Again, in "Demystifying ObamaCare" by David Brown, a doctor, going to page 18, "What Are the Facts About Medicaid and Medicaid Expansion?"

Costs of Medicaid (total federal and state spending) will more than double i.e. more than \$427 billion to \$896 billion between 2014 and 2024. The costs of this will be borne by the taxpayers.

The cost of Medicaid to the states has a tremendous impact on other services. It is often the second most expensive budgetary item. With Medicaid expansion, there are increased costs to the states, even in those states, which have accepted Medicaid expansion and increased federal funding for it. Other state services may have to be reduced even in states who have not accepted Medicaid expansion.

Medicaid is actually a safety net for the poorest and most vulnerable Americans but expansion changes this. It reduces the access to care for others who are already in the system. The single adult able-bodied American is competing for care with those who need the care as a safety net.

It severely underpays doctors and hospitals, and the number of Medicaid providers are declining. It compensates doctors an average of 50% less than private insurance. By CBO estimates, by the time of full implementation of ObamaCare, one out of every six hospitals will be in the red because of severe underpayment from Medicaid and Medicare.

Medicaid expansion does not reduce inappropriate utilization of emergency rooms. A recent study showed Medicaid patients utilize the emergency rooms for their routine care 40% more than those who are uninsured.

Medicaid has the worst clinical outcomes compared with any other medical program. There are worse outcomes including conditions such as heart disease, cancer, complications from major surgery, transplants, and AIDS. These outcomes are independent of patient factors and reflect the program itself. It may be no better than having no insurance at all. A recent study comparing Medicaid patients with those who are uninsured showed no difference in blood pressure, glucose, and cholesterol levels after two years of observation.

In short Medicaid expansion reduces access to care, increases cost of care and places people within the program that has the worst possible outcomes to care.

Going on in "Demystifying ObamaCare," by David Brown, page 25, "Medicaid Expansion Update: How Does It Stand Today?"

Thirty-one states and the District of Columbia have adopted Medicaid expansion. Three states have considered it but rejected Medicaid expansion. The other sixteen states have refused to participate in it.

Medicaid expansion has increased the Medicaid number from 58 million to approximately 70 million people, 20% of the uninsured population. It has caused overall expansion of the number of people in the program.

ObamaCare has increased the number of individuals insured by allowing them to participate in the existing Medicaid program. In order to do so, the inclusion criteria for their enrollments have changed. Medicaid expansion is now based on age and financial criteria. That includes both the able-bodied individuals who are able to work and chose not to and those who were previously involved in the Medicaid safety net. For example, the lower income mother with children.

It was thought that the states that accepted Medicaid expansion would have "free money" if they participated with this Federal program. 100% of the costs of adding new patients were picked up by the federal government with that figure gradually being reduced to 90% of the cost starting in 2017.

This was for new patients added to Medicaid and not the existing patient population. States however found that their Medicaid programs were flooded with new enrollees, many of which had met the criteria for Medicaid before the "woodwork effect."

The overall expansion of Medicaid with increasing numbers of enrollees has led to marked increase in spending on Medicaid and marked increase in total costs for Medicaid.

It goes on with a lot of numbers which have a lot of significance to accountants, but I will skip over those and continue on with his last two points.

Medicaid is associated with the worst possible clinical success rate across the board for all medical and surgical illnesses. It is worse than any other program, including any government programs such as Medicare or any private program. In certain studies, it has shown to have worse clinical outcomes than having no insurance at all. No data has developed during the course of Medicaid expansion to change these findings.

Medicaid expansion is associated with a huge financial burden on the states and the cost to the states with Medicaid expansion has increased dramatically.

Again, at the end of the chapter it shows a lot of references for where he got this information.

Continuing with "Demystifying ObamaCare" and moving on to page 31 is "What are ObamaCare Insurance Exchanges?"

ObamaCare insurance exchanges are federally constructed and state run markets where individuals and families can purchase insurance plans. Private healthcare insurance companies participate but the insurance companies are only able to sell plans that are acceptable to the Secretary of the HHS. Many individuals and families then could receive subsidies provided by the government, (i.e. taxpayers funded subsidies). The subsidies are [to] be on a sliding scale, families whose income is up to 400% of the federal poverty level can be in the ObamaCare exchange (\$97,000 dollars a year for a family of four). The program is tightly regulated by the Federal Government. The choice is limited to four plans (bronze, silver, gold, and platinum.) Each state was required to set up their own insurance exchanges and then regulate them. If a state

did not set up such an exchange, the Federal Government did that for them.

“What Effects These Policies Have on Those Inside and Outside the Exchanges?”

The public must know that the exchanges dramatically restrict patient care by restricting access to care. Exchanges decrease access by reducing access to doctors and hospitals. This includes access to some of the most important specialized care. The exchanges have a limited network of providers.

The public must understand that they do [not have] protection from fraud. Some of the most sensitive information is given to navigators to help enroll people in the exchanges. The enrollees then become “fair game.”

The ObamaCare website, “Healthcare.gov” does not automatically verify enrollee’s eligibility, i.e., whether they legally qualify for subsidies. Various sources indicate that at least 2 million enrollees (some estimates are significantly higher) are receiving subsidies that they did not legally qualify for. Douglas Holtz-Eakins, former director of the CBO, estimates that over the first 10 years of ObamaCare, overpayments and inappropriate payments could add up to \$152 billion dollars. Who pays the bill? The American taxpayer. The website, “Healthcare.gov” cost taxpayers \$1.4 billion dollars in 2014.

He goes on to explain how that increases the costs for all taxpayers.

I will continue with some of the other lessons in this book at another time. The leader is coming to the floor to speak in a few moments.

What we are trying to do is to find some solutions for the American people so they have access to healthcare—and more extensively than now. I recommend for reading this book called “Demystifying ObamaCare” by David Brown. It is very eye-opening. There is a section I will cover later that covers some of the solutions that will be useful.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. RUBIO). The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDER OF BUSINESS

Mr. MCCONNELL. Mr. President, for the information of all Senators, at the request of the President and the Vice President, and after consulting with our Members, we will have the vote on the motion to proceed to the ObamaCare repeal bill early next week.

LEGISLATIVE SESSION

MORNING BUSINESS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Senate be in a period of morning business, with Senators permitted to speak therein for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

FLOODING IN NORTHERN ILLINOIS

Mr. DURBIN. Mr. President, for the second time this year, Illinois communities are assessing damage and cleaning up after flooding. My thoughts and prayers are with the families and first responders in northern Illinois who are working to recover after heavy rain caused severe flooding in Lake, McHenry, Kane, and Cook Counties last week.

The water has started to recede in some communities, but in some areas, water levels will likely continue rising this week. Thousands of buildings—including homes, businesses, and schools—have been damaged by floodwaters.

Lake County has been one of the areas most impacted by this flooding. Last weekend, I visited two towns in this area—Libertyville and Gurnee—and I saw street after street of flood damage to homes and businesses. What I saw was heartbreaking. I spoke with residents who were concerned about being able to recover from the flood and resulting damages and who voiced the need to find long-term solutions that will mitigate the impact of future flood events. I am extremely grateful for the hard work of local first responders and county officials. Thankfully, there have been no reports of injuries or fatalities as a result of this historic flooding.

I want to acknowledge the dedication of both the State and local employees and volunteers who have come out to help at every level, from the Illinois Emergency Management Agency and the American Red Cross, to county emergency management agencies. Many volunteers have helped with sandbagging. County board chairman Aaron Lawlor has also been helpful in securing resources and making sure residents have information about where to find shelter and access clean-up supplies.

People from all around the area are pitching in to help their neighbors and even strangers protect property and get back on their feet.

I would also like to thank James Joseph, director of the Illinois Emergency Management Agency, for his hard work. He has been there during a time when Illinois constituents and communities need him the most.

The State has provided 850,000 sandbags and deployed an emergency management assistance team for flood mitigation and response efforts. Representatives from the Illinois Emergency Management Agency are working closely with local officials to make sure communities have the resources needed to protect critical infrastructure and clean up when water begins to recede.

The Governor has declared four counties State disaster areas. In the coming days, the State will work with FEMA and local officials to begin conducting preliminary damage assessments.

Once we have an idea of the scope of the damage, the Governor has the abil-

ity to request a Presidential disaster declaration. In the past, it has been challenging for Illinois to receive Federal aid after a disaster occurs, but the Illinois delegation and I stand ready to do whatever we can to help get any Federal assistance needed so that these communities can clean up and recover.

There is more work to be done, and cleanup may be difficult and dangerous, but I have no doubt the people who live and work in the impacted communities will make incredible progress rebuilding with the help and support of volunteers, local officials, and State agencies.

I want to thank everyone who has been engaged in the response and mitigation efforts and all those who will be engaged in recovery efforts in the weeks to come. We will rebuild, as Illinoisans always do, and we will be stronger for it.

REMEMBERING BARBARA ANDREWS-MEE

Ms. MURKOWSKI. Mr. President, this Saturday Alaskans will observe “Ted Stevens Day,” a living memory to Alaska’s greatest Senator, who left us 7 years ago next month. As family, friends, and former staffers of Senator Stevens gather in Alaska for this annual observance, many will take time off on Thursday to honor a beloved member of the Stevens’ team, Ted’s loyal assistant and State director, Barbara Andrews-Mee, who passed away earlier this year. I will not be able to attend this event because the Senate will be in session on Thursday, but I wanted to take this opportunity to speak in memory of this loyal and dedicated employee of the U.S. Senate, as well as great friend of Alaska.

Barb’s tenure with Senator Stevens long predates his Senate service. Barb began working with Ted in 1962, 2 years after she came to Alaska. She followed him to the Alaska Legislature and the U.S. Senate, retiring in 1997. Upon her retirement, Stevens said, “For half of my life—and two-thirds of hers—Barbara Andrews-Mee has been my boss. . . .” Barb returned the compliment noting that she had been with Ted Stevens longer than she had been with three husbands.

Barb had a great sense of humor and a huge and welcoming personality. She was regarded as a mentor and grandmother-like figure to generations of young staffers who went to work for Senator Stevens.

She could sure turn a phrase. Alaska humorist Mike Doogan published a few of Barb’s quips in the Anchorage Daily News to celebrate her retirement. Among them, Barb, who was 5-feet tall, once said, “I tell people I used to be 6-foot-2, and then I went to work for Stevens.” But she wasn’t always so humble. Another “Barbism” was “[m]y grandmother always told me dynamite comes in small packages.” I am told that one came in handy when she was working difficult constituent problems

to successful conclusion and building Ted's brand in the process. Whether it was Norwegian stubbornness or Alaskan toughness, she got the job done.

That seemed to be her second best characteristic from Ted's standpoint. In his May 21, 1997, floor tribute to Barb, Senator Stevens said, "When I've been asked what her best characteristic is, I say 'loyalty'. That means more to me than any of the help that she's given me and the people of Alaska over more than three decades; work above and beyond the call of duty."

Barb was quite the worker, delivering care packages to visiting dignitaries whose flights were refueling at what was then called Elmendorf Air Force Base, picking up Senator Stevens at what is now called Ted Stevens Anchorage International Airport, whatever the hour, and making sure he made the flight back to Washington, and supporting servicemembers and military families.

It wasn't all work though. Barb actually christened a Navy PC8 coastal patrol craft, the USS Zephyr. She flew in an F-15, experienced several aircraft carrier landings, and traveled in the submarine, USS Alaska. Then there was golf. In 1995, Barb married Vince Mee, her longtime golfing partner. Senator Stevens performed the ceremony on the ninth hole on Eaglegen golf course on Elmendorf. In 2010, Barb authored a book, "Ted Stevens and Mee," a memoir of her time working with the man they called Alaskan of the Century.

Barb lived a wonderful life—or as she might put it, "A great ride." Devoted to her wonderful family, to her church, and to community service, she came far from humble beginnings in South Dakota, leading to a long drive up the Alcan to Glennallen, AK, and a path to Alaskan greatness. One of the first women in Rotary and a member of the Athena Society of Anchorage, Barb's contributions and leadership will be long remembered.

On behalf of the Senate family, I extend my continued condolences to Barb's family and friends this week as Alaska reflects on her great legacy.

RECOGNIZING UNIDOSUS

Ms. CORTEZ MASTO. Mr. President, today I wish to recognize UnidosUS for its leadership on behalf of the Latino community. On July 25, 2017, the Coalition on Human Needs will honor UnidosUS, formerly known as the National Council of La Raza, as one of its Human Needs Heroes for 2017. For almost 50 years, UnidosUS has been at the forefront of the policy movement to build opportunity for Latinos through civil rights, education, housing, economic advancement, health care, and the defense of immigrants' rights.

UnidosUS ensures that the human face of immigration is always seen and the essential role of immigrants in our

communities is understood. I am proud to work with UnidosUS to advance a fair and moral immigration policy. I am also proud to work with UnidosUS in advancing economic opportunities for Latinos throughout our communities and look forward to our close cooperation in the future.

UnidosUS has a long record of promoting just policies to improve the lives of those in the Latino community. From the Immigration Reform and Control Act of 1986 to the Deferred Action for Childhood Arrivals, DACA, program, UnidosUS has been a trusted source and advocate on immigration policy. The ability of UnidosUS to serve as a broad voice that reflects the views and needs of Latinos across the country ensures that the debate on immigration never forgets the impact on families and communities. It is my honor today to recognize UnidosUS and thank them for all they have done on behalf of Latinos and immigrants.

ADDITIONAL STATEMENTS

200TH ANNIVERSARY OF MONROE COUNTY, MICHIGAN

• Mr. PETERS. Mr. President, today I wish to recognize the 200th anniversary of Monroe County, MI. Situated in southeast Michigan on the west shore of Lake Erie, Monroe County is endowed with rich historical and natural treasures, built on a strong agricultural base, home to innovative industries, and populated with dedicated citizens and entrepreneurs.

Founded by Potawatomi Tribes and, later, French missionaries, the history of Monroe County dates back to 1634. French missionaries built the first settlement, named Frenchtown, on the territory and established both a trading post and fort in 1788. The River Raisin provided an agricultural center for the residents of Frenchtown, with an abundance of natural resources to contribute to economic growth. However, in 1813, the Battle of the River Raisin occurred near Frenchtown, resulting in mass human and economic loss. Recognized as the deadliest battle recorded during the War of 1812, the U.S. Congress included the River Raisin National Battlefield Park as part of the National Park Service in 2009, the only national park that commemorates the human contributions and historic legacy of the War of 1812.

As one of the first steps in organizing the Michigan Territory after the War of 1812, Governor Lewis Cass established Monroe County in 1817 as the second county in the State of Michigan. At the time, Monroe County included all of Lenawee and portions of Wayne and Washtenaw Counties. The old settlement of Frenchtown adopted the name "Monroe" in honor of President James Monroe and became the county seat. The flourishing county experienced economic growth and prosperity from the agricultural and paper

manufacturing industries, from the first paper mill, Raisinville Mill, in 1834, to River Raisin Paper Company in 1910, to IKO Monroe, Incorporated, in 2000.

In the early 20th century, Monroe County hit another industrial milestone with the establishment of Monroe Auto Equipment World Headquarters, formerly referred to as Brisk Blast, in 1916, and the Newton Steel plant in 1959. Monroe County gained the reputation as the transportation hub in the State of Michigan, home to international ports on Lake Erie and one of the largest highway gateways into Michigan. The development of transportation infrastructure played a crucial role in connecting the residents of Monroe County to goods and services. Monroe County also attracted entrepreneurs and inventors from across the United States, including Edward Knabush and Edwin Shoemaker who revolutionized furniture design and comfort when they invented the first upholstered reeling chair in 1929.

Today Monroe County is a vibrant community of nearly 150,000 residents who enjoy historic downtowns, beautiful parks, and safe neighborhoods. Residing along the shoreline of the River Raisin and Lake Erie, Monroe County offers a multitude of recreational activities—boating, swimming, camping, hiking, and fishing—at the Eagle Island Marsh unit of the Detroit River International Wildlife Refuge and Sterling State Park. Monroe County is also active in the preservation and promotion of its history by recognizing significant landmarks and sites, including the Dundee Old Mill Museum and Navarre Anderson Trading Post. With its rich historical and natural resources, Monroe County is recognized as one of the top visitor destinations in the State of Michigan.

Monroe County has been an integral part of the State of Michigan and our great Nation for 200 years. As Monroe County celebrates this milestone, I am honored to ask my colleagues to join me in congratulating its residents, elected officials, and businesses as they recognize their history. I wish the county continued growth and prosperity in the years ahead.●

MESSAGE FROM THE HOUSE

At 12:15 p.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the House has passed the following bills and joint resolutions, in which it requests the concurrence of the Senate:

H.R. 23. An act to provide for drought relief in the State of California, and for other purposes.

H.R. 2210. An act to designate the community living center of the Department of Veterans Affairs in Butler Township, Butler County, Pennsylvania, as the "Sergeant Joseph George Kusick VA Community Living Center".

H.R. 2810. An act to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities

of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

H.J. Res. 76. Joint resolution granting the consent and approval of Congress for the Commonwealth of Virginia, the State of Maryland, and the District of Columbia to enter into a compact relating to the establishment of the Washington Metrorail Safety Commission.

H.J. Res. 92. Joint resolution granting the consent and approval of Congress for the Commonwealth of Virginia, the State of Maryland, and the District of Columbia to amend the Washington Area Transit Regulation Compact.

MEASURES REFERRED

The following bill and joint resolution were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 23. An act to provide drought relief in the State of California, and for other purposes; to the Committee on Energy and Natural Resources.

H.J. Res. 92. Joint resolution granting the consent and approval of Congress for the Commonwealth of Virginia, the State of Maryland, and the District of Columbia to amend the Washington Area Transit Regulation Compact; to the Committee on the Judiciary.

MEASURES PLACED ON THE CALENDAR

The following bill and joint resolution were read the first and second times by unanimous consent, and placed on the calendar:

H.R. 2810. An act to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

H.J. Res. 76. Joint resolution granting the consent and approval of Congress for the Commonwealth of Virginia, the State of Maryland, and the District of Columbia to enter into a compact relating to the establishment of the Washington Metrorail Safety Commission.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC-2244. A communication from the Secretary of Defense, transmitting the report of an officer authorized to wear the insignia of the grade of rear admiral (lower half) in accordance with title 10, United States Code, section 777; to the Committee on Armed Services.

EC-2245. A communication from the Assistant General Counsel, General Law, Ethics, and Regulation, Department of the Treasury, transmitting, pursuant to law, a report relative to a vacancy in the position of Comptroller of the Currency, Department of the Treasury, received in the Office of the President of the Senate on July 12, 2017; to the Committee on Banking, Housing, and Urban Affairs.

EC-2246. A communication from the Assistant General Counsel, General Law, Ethics,

and Regulation, Department of the Treasury, transmitting, pursuant to law, a report relative to a vacancy in the position of Under Secretary (Terrorism and Financial Intelligence), Department of the Treasury, received in the Office of the President of the Senate on July 12, 2017; to the Committee on Banking, Housing, and Urban Affairs.

EC-2247. A communication from the Deputy Assistant Secretary for Export Administration, Bureau of Industry and Security, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled "Revisions to the Export Administration Regulations Based on the 2016 Missile Technology Control Regime Plenary Agreements" (RIN0694-AH33) received in the Office of the President of the Senate on July 12, 2017; to the Committee on Banking, Housing, and Urban Affairs.

EC-2248. A communication from the Senior Counsel, Legal Division, Bureau of Consumer Financial Protection, transmitting, pursuant to law, the report of a rule entitled "Prepaid Accounts Under the Electronic Fund Transfer Act (Regulation E) and the Truth in Lending Act (Regulation Z); Delay of Effective Date" (RIN3170-AA69) received in the Office of the President of the Senate on July 12, 2017; to the Committee on Banking, Housing, and Urban Affairs.

EC-2249. A communication from the Acting Director, Office of Surface Mining Reclamation and Enforcement, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled "Pennsylvania Regulatory Program" ((30 CFR Part 938) (Docket ID OSM-2016-0013)) received in the Office of the President of the Senate on July 17, 2017; to the Committee on Energy and Natural Resources.

EC-2250. A communication from the Director of the Regulatory Management Division, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Address and Name Changes for Region 4 State and Local Agencies; Technical Correction" (FRL No. 9964-36-Region 4) received in the Office of the President of the Senate on July 12, 2017; to the Committee on Environment and Public Works.

EC-2251. A communication from the Director of the Regulatory Management Division, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Approval of Air Quality Implementation Plans; Puerto Rico; Attainment Demonstration for the Arecibo Area for the 2008 Lead National Ambient Air Quality Standards" (FRL No. 9964-87-Region 2) received in the Office of the President of the Senate on July 12, 2017; to the Committee on Environment and Public Works.

EC-2252. A communication from the Director of the Regulatory Management Division, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Approval and Promulgation of Air Quality Implementation Plans; Maryland; Removal of Clean Air Interstate Rule Program Regulations (CAIR) and Reference to CAIR, and Amendments to Continuous Emission Monitor (CEM Reference)" (FRL No. 9964-79-Region 3) received in the Office of the President of the Senate on July 12, 2017; to the Committee on Environment and Public Works.

EC-2253. A communication from the Director of the Regulatory Management Division, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Air Plan Approval; NC; Open Burning and Miscellaneous Revisions" (FRL No. 9965-02-Region 4) received in the Office of the President of the Senate on July 12, 2017; to the Committee on Environment and Public Works.

EC-2254. A communication from the Director of the Regulatory Management Division,

Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Air Plan Approval; Maine; Motor Vehicle Fuel Requirements" (FRL No. 9964-80-Region 1) received in the Office of the President of the Senate on July 12, 2017; to the Committee on Environment and Public Works.

EC-2255. A communication from the Director of the Regulatory Management Division, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Air Plan Approval; Maine; Decommissioning of Stage II Vapor Recovery Systems" (FRL No. 9964-81-Region 1) received in the Office of the President of the Senate on July 12, 2017; to the Committee on Environment and Public Works.

EC-2256. A communication from the Director of the Regulatory Management Division, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Louisiana: Final Authorization of State Hazardous Waste Management Program Revision" (FRL No. 9962-37-Region 6) received in the Office of the President of the Senate on July 12, 2017; to the Committee on Environment and Public Works.

EC-2257. A communication from the Director of the Regulatory Management Division, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "National Emissions Standards for Hazardous Air Pollutants for Wool Fiberglass Manufacturing; Flame Attenuation Lines" (FRL No. 9964-89-OAR) received in the Office of the President of the Senate on July 12, 2017; to the Committee on Environment and Public Works.

EC-2258. A communication from the Director of the Regulatory Management Division, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Oklahoma: Final Authorization of State Hazardous Waste Management Program Revision" (FRL No. 9962-39-Region 6) received in the Office of the President of the Senate on July 12, 2017; to the Committee on Environment and Public Works.

EC-2259. A communication from the Wildlife Biologist, Fish and Wildlife Service, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled "Migratory Bird Hunting; Final Frameworks for Migratory Bird Hunting Regulations" (RIN1018-BB40) received in the Office of the President of the Senate on July 12, 2017; to the Committee on Environment and Public Works.

EC-2260. A communication from the Assistant General Counsel, General Law, Ethics, and Regulation, Department of the Treasury, transmitting, pursuant to law, a report relative to a vacancy in the position of Assistant Secretary for Terrorist Financing, received in the Office of the President of the Senate on July 12, 2017; to the Committee on Banking, Housing, and Urban Affairs.

EC-2261. A communication from the Regulations Coordinator, Centers for Medicare and Medicaid Services, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled "Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities" ((RIN0938-AR61) (CMS-3260-F2)) received in the Office of the President of the Senate on July 12, 2017; to the Committee on Finance.

EC-2262. A communication from the Chief of the Trade and Commercial Regulations Branch, Customs and Border Protection, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Modernization of the Customs Brokers Examination" ((RIN1651-AB07) (CBP Dec. 17-05)) received during adjournment of the Senate in the Office of the President of

the Senate on June 29, 2017; to the Committee on Finance.

EC-2263. A communication from the Acting Assistant Attorney General, Office of Legislative Affairs, Department of Justice, transmitting, pursuant to law, a report entitled "Report of the Attorney General to the Congress of the United States on the Administration of the Foreign Agents Registration Act of 1938, as amended, for the six months ending December 31, 2016"; to the Committee on Foreign Relations.

EC-2264. A communication from the Secretary of Education, transmitting, pursuant to law, the report of a rule entitled "Rosa's Law" (RIN1801-AA11) received in the Office of the President pro tempore of the Senate; to the Committee on Health, Education, Labor, and Pensions.

EC-2265. A communication from the Associate General Counsel for General Law, Department of Homeland Security, transmitting, pursuant to law, a report relative to a vacancy in the position of Under Secretary for Intelligence and Analysis, Department of Homeland Security, received in the Office of the President of the Senate on July 12, 2017; to the Select Committee on Intelligence.

PETITIONS AND MEMORIALS

The following petitions and memorials were laid before the Senate and were referred or ordered to lie on the table as indicated:

POM-60. A joint resolution adopted by the Legislature of the State of Maine memorializing the United States Congress to reduce tariffs on Maine and lobster and seafood products to keep Maine and domestic lobster and seafood products competitive with Canadian lobster and seafood products; to the Committee on Commerce, Science, and Transportation.

H.P. 1120

We, your Memorialists, the Members of the One Hundred and Twenty-eighth Legislature of the State of Maine now assembled in the First Regular Session, most respectfully present and petition the United States Congress as follows:

Whereas, the value of marine resources commercially harvested in Maine exceeded \$700 million in 2016, and the value of lobster harvested in Maine accounts for over \$533 million of that amount; and

Whereas, total exports from Maine to the European Union exceeded \$503 million in 2016; and

Whereas, exports from Maine of lobster to the European Union totaled approximately \$158 million, or approximately 80% of all lobster exported from the United States to the European Union, in 2016; and

Whereas, the European Union is the largest global fish and seafood market in the world; and

Whereas, Maine and Canada share the same lobster species and compete for market share in the European Union and around the world; and

Whereas, the European Union imposes tariffs on fish and seafood products that range from 2% on certain types of salmon to 20% on processed lobster imported from both the United States and Canada; and

Whereas, the Comprehensive Economic and Trade Agreement, or CETA, is a free trade agreement between Canada and the European Union that will reduce tariffs on fish and seafood products exported from Canada to the European Union; and

Whereas, CETA will go into effect on the first day of the month following the date the European Union and Canada notify each other that each has completed all necessary procedures for implementation; and

Whereas, when CETA takes effect, the 8% tariff on live lobster exports from Canada to the European Union will be immediately eliminated, the 6% to 16% tariff on frozen lobster exports from Canada to the European Union will be eliminated over 3 years and the 20% tariff on processed lobster exports from Canada to the European Union will be eliminated over 5 years; and

Whereas, while tariffs on lobster and seafood products exported from Canada to the European Union are being eliminated, tariffs on Maine and other domestic lobster and seafood products exported to the European Union will remain; and

Whereas, the elimination of tariffs on Canadian lobster and seafood products will increase trade between Canada and the European Union, resulting in economic injury to Maine and other domestic lobster and seafood harvesters and processors; and

Whereas, the impact of CETA on Maine lobster harvesters, who landed over 130 million pounds of lobster in 2016, should be minimized; and

Whereas, the impact of CETA on Maine lobster dealers, who support 675 jobs and paid \$28.4 million in wages in 2016, should be minimized; and

Whereas, under the United States Constitution, Article I, the Congress of the United States has the power to regulate commerce with foreign nations; now, therefore, be it

Resolved, That We, your Memorialists, on behalf of the people we represent, take this opportunity to respectfully request that the United States Congress, under the provisions of Article I of the United States Constitution, negotiate to reduce tariffs on Maine and domestic lobster and seafood products, or otherwise mitigate the effects of CETA, to ensure that historical, lucrative industries are not damaged by the economic disadvantage that will result from CETA unless these negotiations are undertaken; and be it further

Resolved, That suitable copies of this resolution, duly authenticated by the Secretary of State, be transmitted to the President of the United States Senate, to the Speaker of the United States House of Representatives and to each Member of the Maine Congressional Delegation.

POM-61. A resolution adopted by the House of Representatives of the State of Michigan urging the President of the United States and the United States Congress to continue funding the Essential Air Service program throughout Michigan; to the Committee on Commerce, Science, and Transportation.

HOUSE RESOLUTION NO. 59

Whereas, the Essential Air Service program was established after airlines were deregulated to ensure that small communities previously served by certificated airlines maintained commercial service. The Essential Air Service program is used to help provide business leaders, recreationalists, and residents reliable air travel to and from small airports around the country, including five airports in Michigan's Upper Peninsula, and has transported countless individuals since the program's enactment; and

Whereas, the Essential Air Service program is important to the economic well-being of northern Michigan and the Upper Peninsula in towns such as Alpena, Muskegon, Pelleton, Escanaba, Iron Mountain, Ironwood, Sault Ste. Marie, Manistee, and Houghton-Hancock. Northern Michigan is renowned for its vast mineral deposits and rugged wilderness that have long supplied American industry with affordable, domestically-mined metals and timbers for manufacturing. The region's breathtaking scenery

and lakeshore are some of the most stunning in the Midwest. Such a large expanse requires reliable air travel to make the region's mines, forests, lakeshores, communities, and colleges as accessible as possible; and

Whereas, President Trump has asked for a reduction in the Essential Air Service's budget. Businesses depend on reliable air travel to and from small airports in northern Michigan and the Upper Peninsula, and airports require funding from the Essential Air Service program to maintain critical infrastructure like runways, lighting, and safety equipment. Any reduction in federal funding for this vital program will harm economic activity in the Upper Peninsula and have a direct and negative impact on American manufacturing and these communities; now, therefore, be it

Resolved by the House of Representatives, That we urge the Congress and President of the United States to continue to fund the Essential Air Service program throughout Michigan; and be it further

Resolved, That copies of this resolution be transmitted to the President of the United States, the President of the United States Senate, the Speaker of the United States House of Representatives, and the members of the Michigan congressional delegation.

POM-62. A resolution adopted by the Senate of the Commonwealth of Pennsylvania recognizing the month of May 2017 as "Amyotrophic Lateral Sclerosis Awareness Month"; to the Committee on the Judiciary.

SENATE RESOLUTION NO. 126

Whereas, Amyotrophic lateral sclerosis (ALS) is better known as Lou Gehrig's Disease; and

Whereas, ALS is a fatal neurodegenerative disease characterized by degeneration of cell bodies of the upper and lower motor neurons in the gray matter of the anterior horn of the spinal cord; and

Whereas, The initial symptoms of ALS is weakness of the skeletal muscles, especially those of the extremities; and

Whereas, As ALS progresses, the patient experiences difficulty in swallowing, talking and breathing; and

Whereas, ALS eventually causes muscles to atrophy and the patient becomes a functional quadriplegic; and

Whereas, Patients with ALS typically remain alert and are aware of their loss of motor functions and the inevitable outcome of continued deterioration and death; and

Whereas, ALS affects military veterans at twice the rate of the general populations; and

Whereas, ALS occurs in adulthood, most commonly between 40 and 70 years of age; peaking at approximately 55 years of age, and affects both men and women without bias; and

Whereas, Annually, more than 5,000 new ALS patients are diagnosed throughout the nation; and

Whereas, In Pennsylvania, there are currently more than 1,000 individuals who have been formally diagnosed with ALS; and

Whereas, The \$350,000 in State funding appropriated by the General Assembly for ALS support services in the Supplement to the General Appropriation Act of 2015 provided services to more than 900 constituents and a substantial savings to the State budget and taxpayers; and

Whereas, The ALS Association reports that on average, patients diagnosed with ALS only survive two to five years from the time of diagnosis; and

Whereas, ALS has no known cause, prevention or cure; and

Whereas, "Amyotrophic Lateral Sclerosis Awareness Month" increases the public's

awareness of ALS patients' circumstances and acknowledges the negative impact this disease has on ALS patients and their families and recognizes the research being done to eradicate ALS; therefore be it

Resolved, That the Senate designate the month of May 2017 as "Amyotrophic Lateral Sclerosis Awareness Month" in Pennsylvania; and be it further

Resolved, That copies of this resolution be transmitted to the President of the United States and to the presiding officers and members of the Pennsylvania Delegation in the Congress of the United States.

POM-63. A joint resolution adopted by the General Assembly of the State of Colorado designating March 20, 2017, as "Colorado Aerospace Day"; to the Committee on the Judiciary.

SENATE JOINT RESOLUTION 17-019

Whereas, Our nation and the world have significantly benefitted from technological and scientific advances resulting from space exploration and aerospace activities; and

Whereas, Colorado is the second-largest state in the country for private aerospace employment; 25,500 Coloradans are directly employed in aerospace, with a payroll exceeding \$3.4 billion, and Colorado's aerospace cluster supports more than 188,000 jobs; and

Whereas, Colorado is home to the nation's top aerospace companies, including Ball Aerospace, Boeing, DigitalGlobe, Harris Corporation, Lockheed Martin Space Systems, Northrop Grumman, Raytheon, Sierra Nevada Corporation, Teledyne Brown Engineering, and United Launch Alliance; and close to 500 additional companies that support the aerospace sector by developing products, including spacecraft, launch vehicles, satellites, command and control software, sensors, and navigation operations; and

Whereas, The United States Air Force Academy, along with Colorado's colleges and universities, including the University of Colorado Boulder and University of Colorado Colorado Springs, Colorado School of Mines, Colorado State University, Metropolitan State University of Denver, University of Denver, Colorado Mesa University and Fort Lewis College provide access to world-class aerospace-related degrees and offer aerospace companies one of the country's most educated workforces; and

Whereas, Colorado is the home of the Laboratory for Atmospheric and Space Physics (LASP) at the University of Colorado Boulder that began in 1948, a decade before NASA, and is the world's only research institute to have sent instruments to all eight planets and Pluto and combines all aspects of space exploration through science, engineering, mission operations, and scientific data analysis; and

Whereas, Colorado is home to NOAA's Space Weather Prediction Center, a world-leading center of predictions of the solar and near-Earth space environment and the nation's official source of watches, warnings, and alerts of incoming solar storms, using satellite observations to protect and save lives and property; and

Whereas, Colorado is a strategic location for national space and cyber activity, with five key military commands—North American Aerospace Defense Command (NORAD), the United States Northern Command (USNORTHCOM), the U.S. Strategic Command's Joint Functional Component Command for Space (JFCC-Space) Missile Warning Center, the United States Air Force Space Command, and the U.S. Army Space and Missile Defense Command/Army Forces Strategic Command and three space-related United States Air Force bases—Buckley, Peterson, and Schriever; and

Whereas, The 460th Space Wing at Buckley Air Force Base, located in Aurora, provides operational command and control of three

constellations of space-based infrared missile warning systems, has been defending America continuously since 1970, and is a critical part of global defense and national security; and

Whereas, Colorado is uniting global partners around the world to ensure space access for developing nations via the first planned United Nations space mission—Sierra Nevada Corporation located in Louisville, Colorado, together with the United Nations Office of Outer Space Affairs, will use its Dream Chaser spacecraft to allow developing countries the opportunity to develop and fly microgravity payloads for an extended duration in orbit; and

Whereas, Colorado leads the charge in bringing current and future GPS assets to life, a service provided free to the world by Air Force Space Command in Colorado Springs; and

Whereas, From the operation of GPS satellites by Schriever Air Force Base, to GPS III, the most powerful GPS satellite to date being designed and built by Lockheed Martin and launched by United Launch Alliance with Raytheon developing the command and control capabilities, and companies such as Boeing, Harris Corporation, Braxton Technologies, and Infinity Systems Engineering also supporting GPS development and operations from locations in Colorado, Colorado's GPS technologies enable an integral part of our global economy to have an incalculable impact that has improved the everyday lives of billions of people around the world; and

Whereas, Various organizations are key to Colorado's prominence in aerospace, such as the Colorado Space Coalition (CSC), a group of industry stakeholders working to make Colorado a center of excellence for aerospace; the Colorado Space Business Roundtable, working to bring together aerospace stakeholders from the industry, government, and academia for roundtable discussions and business development and to encourage grassroots citizen participation in aerospace issues; the Colorado Chapter of Citizens for Space Exploration, whose mission is to promote better understanding of aerospace and its importance in our economy and daily lives as well as promoting the importance of human space exploration; and Manufacturer's Edge, a statewide manufacturing assistance center that encourages the strength and competitiveness of Colorado manufacturers by providing on-site technical assistance through coaching, training, and consulting and collaboration-focused industry programs and leveraging government, university, and economic development partnerships: Now, therefore, be it

Resolved, By the Senate of the Seventieth-first General Assembly of the State of Colorado, the House of Representatives concurring herein:

That we, the members of the Colorado General Assembly:

(1) Strongly urge and request the government of the United States of America to take action to preserve and enhance United States leadership in space, spur innovation, and ensure our continued national and economic security by increasing funding for space exploration and activities, including regaining the ability of the United States to deliver astronauts to low earth orbit in the next few years; to commit to sending astronauts to the moon, asteroids, and beyond within this decade; and to aggressively pursue NASA's Orion spacecraft and Space Launch System to get astronauts to Mars orbit by 2028 and boots on the ground by 2033;

(2) Recognize and appreciate Colorado's space and aerospace companies and organizations, especially the growing membership and activities of the Colorado Chapter of Citizens for Space Exploration, whose activities to promote space exploration are helping to increase public understanding and enthusiasm for exploration funding;

(3) Recognize and appreciate the contributions of Colorado's universities, colleges, and national research laboratories to the space and aerospace industries, including their expertise in exploration of the planets and the universe and space-based Earth observation;

(4) Express our most sincere and deepest appreciation to the men and women working in and supporting military and civilian aerospace companies and organizations in Colorado; and

(5) Hereby declare March 20, 2017, to be "Colorado Aerospace Day"; and be it further

Resolved, That copies of this Joint Resolution be sent to President Donald Trump; Vice President Mike Pence; Speaker Paul D. Ryan; House Minority Leader Nancy Pelosi; Senate Majority Leader Mitch McConnell; Senate Minority Leader Charles Schumer; Senator Cory Gardner; Senator Michael Bennet; Congresswoman Diana DeGette; Congressman Jared Polis; Congressman Scott Tipton; Congressman Ken Buck; Congressman Doug Lamborn; Congressman Mike Coffman; Congressman Ed Perlmutter; Robert Lightfoot, Acting NASA Administrator; Lesa Roe, Acting NASA Deputy Administrator; Mr. Michael P. Huerta, Federal Aviation Administration Administrator; Governor John Hickenlooper; Lieutenant Governor Donna Lynne; Major General H. Michael Edwards, Adjutant General, Colorado National Guard; Dr. George C. Nield, Associate Administrator for Commercial Space Transportation at the Federal Aviation Administration; General John Raymond, Air Force Space Commander; Colonel Dan Wright, USAF, Commander Aerospace Data Facility-Colorado; Betty Sapp, Director, National Reconnaissance Office; Charles Huettnet, Executive Director, Aerospace States Association; Lieutenant Colonel Shelli Brunswick, Acting Chief Executive Officer, Space Foundation; Major General (Retired) Andy Love, Co-Chair, Colorado Space Coalition; Tom Marsh, Co-Chair, Colorado Space Coalition; Rick Ward, Chair, Colorado Space Business Roundtable; and Stacey DeFore, Chair, Colorado Citizens for Space Exploration.

POM-64. A joint resolution adopted by the Legislature of the State of Nevada rescinding all previous resolutions of the Nevada Legislature which requested Congress to convene a convention to propose amendments to the United States Constitution; to the Committee on the Judiciary.

SENATE JOINT RESOLUTION NO. 10

Whereas, The Constitutional Convention of 1787 was initially convened to make revisions to the Articles of Confederation and this Convention decided instead to discard the Articles of Confederation entirely and create a new system of government; and

Whereas, The United States Constitution has served as the cornerstone of American liberty since its creation in 1787 and was the first written national constitution to set forth a system of separation of powers and to ensure that the rights of minority groups could not be easily trampled upon by the will of the majority; and

Whereas, Despite turmoil and grave political and economic concerns, including, without limitation, the contested presidential elections of 1800, 1876 and 2000, the Civil War and the Great Depression, a subsequent constitutional convention has not been held since 1787; and

Whereas, The United States Constitution has proven to be resilient and has been amended only 27 times during the course of its 230-year history; and

Whereas, Article V of the United States Constitution requires the Congress of the United States to convene a constitutional convention upon the application of two-thirds of the several states; and

Whereas, The Nevada Legislature has, at various times, passed resolutions requesting Congress to convene a convention, pursuant to Article V of the United States Constitution, to propose amendments to the Constitution relating to a wide range of subjects; and

Whereas, Over the course of time, the will of the people of the State of Nevada may have changed relating to these resolutions; and

Whereas, A constitutional convention convened by Congress could make sweeping changes to the United States Constitution and threaten the liberty of future generations of Nevadans; and

Whereas, The Nevada Legislature is aware that other state legislatures have made applications requesting that Congress convene a constitutional convention; and

Whereas, The Nevada Legislature no longer supports its previous resolutions which requested that Congress convene a constitutional convention, most of which were adopted over three decades ago, and does not wish for these resolutions to be included with similar applications which were made by other state legislatures; Now, therefore, be it

Resolved, By the Senate and Assembly of the State of Nevada, Jointly, That the members of the 79th Session of the Nevada Legislature hereby rescind, repeal, cancel, void, nullify and supersede each previous resolution passed by the Nevada Legislature which requested the Congress of the United States to convene a constitutional convention pursuant to Article V of the United States Constitution; and be it further

Resolved, That the members of the 79th Session of the Nevada Legislature urge each state legislature which requested Congress to convene a constitutional convention to withdraw such applications; and be it further

Resolved, That the Secretary of the Senate prepare and transmit a copy of this resolution to the Vice President of the United States as the presiding officer of the United States Senate, the Speaker of the United States House of Representatives and each member of the Nevada Congressional Delegation; and be it further

Resolved, That this resolution becomes effective upon passage.

POM-65. A joint resolution adopted by the Legislature of the State of Texas applying to the United States Congress to call a convention of the states under Article V of the United States Constitution for the limited purpose of proposing one or more amendments to the United States Constitution, which impose fiscal restraints on the federal government, limit the power and jurisdiction of the federal government, and limit the terms of office for federal officials and members of Congress; to the Committee on the Judiciary.

SENATE JOINT RESOLUTION NO. 2

Whereas, The drafters of the United States Constitution empowered state legislatures to be guardians of liberty against abuses of power by the federal government; and

Whereas, The federal government has abused its power by creating a crushing national debt through improper and imprudent spending; and

Whereas, The federal government has abused its power by invading the legitimate role of the states through the manipulative process of federal mandates that are to a great extent unfunded; and

Whereas, The federal government has ceased to abide by a proper interpretation of the United States Constitution; and

Whereas, It is the solemn duty of state legislatures to protect the liberty of the people and of future generations by proposing amendments to the United States Constitution that place clear restraints on federal power; and

Whereas, Article V of the United States Constitution authorizes the several state legislatures to restrict the power of the federal government through the amendment process; and

Whereas, Article V of the United States Constitution provides that on application of the legislatures of two-thirds of the several states Congress shall call a convention for the purpose of proposing amendments to the constitution: Now, therefore, be it

Resolved, That the 85th Texas Legislature apply to Congress to call a convention under Article V of the United States Constitution for the limited purpose of proposing one or more amendments to the constitution to impose fiscal restraints on the federal government, to limit the power and jurisdiction of the federal government, and to limit the terms of office of federal officials and members of Congress; and, be it further

Resolved, That, unless rescinded by a succeeding legislature, this application by the 85th Texas Legislature constitutes a continuing application in accordance with Article V of the United States Constitution until at least two-thirds of the legislatures of the several states have applied to Congress to call a convention for the limited purpose of proposing one or more amendments to the constitution to impose fiscal restraints on the federal government, to limit the power and jurisdiction of the federal government, and to limit the terms of office of federal officials and members of Congress; and, be it further

Resolved, That the Texas secretary of state forward official copies of this resolution to the president of the United States, to the speaker of the House of Representatives and the president of the Senate of the Congress of the United States, and to all members of the Texas delegation to Congress with the request that this resolution be officially entered in the Congressional Record as an application to Congress for a convention under Article V of the United States Constitution for the limited purpose of proposing one or more amendments to the constitution to impose fiscal restraints on the federal government, to limit the power and jurisdiction of the federal government, and to limit the terms of office of federal officials and members of Congress; and, be it further

Resolved, That the Texas secretary of state forward official copies of this resolution to the secretaries of state and to the presiding officers of the legislatures of the several states with the request that they join this state in applying to Congress for a convention under Article V of the United States Constitution for the limited purpose of proposing one or more amendments to the constitution to impose fiscal restraints on the federal government, to limit the power and jurisdiction of the federal government, and to limit the terms of office of federal officials and members of Congress.

POM-66. A resolution adopted by the Mayor and City Commission of the City of Miami Beach, Florida, urging the President of the United States and the United States Congress to grant temporary protective status to Haitians in the United States; to the Committee on the Judiciary.

POM-67. A resolution adopted by the Township Council of the Township of Mahwah, New Jersey, recognizing June 2, 2017, as National Gun Violence Awareness Day; to the Committee on the Judiciary.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. HATCH:

S. 1572. A bill to amend the Mineral Leasing Act to provide that extraction of helium from gas produced under a Federal mineral lease shall maintain the lease as if the helium were oil and gas; to the Committee on Energy and Natural Resources.

By Mr. COONS (for himself and Mrs. CAPITO):

S. 1573. A bill to authorize the Secretary of the Interior and the Secretary of Agriculture to place signage on Federal land along the trail known as the "American Discovery Trail", and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. CORNYN (for himself, Mr. BOOZMAN, Mr. CASSIDY, and Mr. RUBIO):

S. 1574. A bill to impose sanctions on individuals who are complicit in human rights abuses committed against nationals of Vietnam or their family members, and for other purposes; to the Committee on Foreign Relations.

By Mr. WHITEHOUSE (for himself, Mr. CASEY, and Mrs. SHAHEEN):

S. 1575. A bill to amend the Internal Revenue Code of 1986 to provide a tax credit for taxpayers who remove lead-based hazards; to the Committee on Finance.

By Mr. BENNET (for himself, Mr. DAINES, Mr. TESTER, Mr. GARDNER, Mr. WYDEN, and Mr. MERKLEY):

S. 1576. A bill to provide that the owner of a water right may use the water for the cultivation of industrial hemp, if otherwise authorized by State law; to the Committee on the Judiciary.

By Mr. HATCH (for himself, Mr. GRASSLEY, Mr. CORNYN, Mr. LEE, Mr. CRUZ, Mr. SASSE, Mr. FLAKE, Mr. CRAPO, Mr. TILLIS, Mr. KENNEDY, and Mr. LANKFORD):

S. 1577. A bill to amend title 5, United States Code, with respect to the judicial review of agency interpretations of statutory and regulatory provisions; to the Committee on the Judiciary.

ADDITIONAL COSPONSORS

S. 425

At the request of Mr. CARDIN, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of S. 425, a bill to amend the Internal Revenue Code of 1986 to improve the historic rehabilitation tax credit, and for other purposes.

S. 540

At the request of Mr. THUNE, the name of the Senator from Iowa (Mr. GRASSLEY) was added as a cosponsor of S. 540, a bill to limit the authority of States to tax certain income of employees for employment duties performed in other States.

S. 635

At the request of Mrs. SHAHEEN, the name of the Senator from Wisconsin (Ms. BALDWIN) was added as a cosponsor of S. 635, a bill to amend title 28, United States Code, to prohibit the exclusion of individuals from service on a Federal jury on account of sexual orientation or gender identity.

S. 652

At the request of Mr. PORTMAN, the name of the Senator from Massachusetts (Ms. WARREN) was added as a cosponsor of S. 652, a bill to amend the Public Health Service Act to reauthorize a program for early detection, diagnosis, and treatment regarding deaf and hard-of-hearing newborns, infants, and young children.

S. 720

At the request of Mr. CARDIN, the name of the Senator from Louisiana (Mr. CASSIDY) was added as a cosponsor of S. 720, a bill to amend the Export Administration Act of 1979 to include in the prohibitions on boycotts against allies of the United States boycotts fostered by international governmental organizations against Israel and to direct the Export-Import Bank of the United States to oppose boycotts against Israel, and for other purposes.

S. 926

At the request of Mrs. ERNST, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. 926, a bill to authorize the Global War on Terror Memorial Foundation to establish the National Global War on Terrorism Memorial as a commemorative work in the District of Columbia, and for other purposes.

S. 1024

At the request of Mr. ISAKSON, the name of the Senator from New Hampshire (Mrs. SHAHEEN) was added as a cosponsor of S. 1024, a bill to amend title 38, United States Code, to reform the rights and processes relating to appeals of decisions regarding claims for benefits under the laws administered by the Secretary of Veterans Affairs, and for other purposes.

S. 1122

At the request of Mrs. MURRAY, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 1122, a bill to amend the Occupational Safety and Health Act of 1970 to clarify when the time period for the issuance of citations under such Act begins and to require a rule to clarify that an employer's duty to make and maintain accurate records of work-related injuries and illnesses is an ongoing obligation.

S. 1182

At the request of Mr. YOUNG, the names of the Senator from Hawaii (Ms. HIRONO) and the Senator from Pennsylvania (Mr. CASEY) were added as cosponsors of S. 1182, a bill to require the Secretary of the Treasury to mint commemorative coins in recognition of the 100th anniversary of The American Legion.

S. 1356

At the request of Mr. INHOFE, the name of the Senator from New Mexico (Mr. HEINRICH) was added as a cosponsor of S. 1356, a bill to amend title 38, United States Code, to authorize the use of Post-9/11 Educational Assistance to pursue independent study programs at certain educational institutions that are not institutions of higher learning, and for other purposes.

S. 1404

At the request of Mr. CRUZ, the names of the Senator from West Virginia (Mrs. CAPITO) and the Senator from Oklahoma (Mr. INHOFE) were added as cosponsors of S. 1404, a bill to amend the Natural Gas Act to provide for expanded natural gas exports.

S. 1414

At the request of Mr. WICKER, the name of the Senator from California (Ms. HARRIS) was added as a cosponsor of S. 1414, a bill to state the policy of the United States on the minimum number of available battle force ships.

S. 1455

At the request of Mr. FLAKE, the name of the Senator from Idaho (Mr. CRAPO) was added as a cosponsor of S. 1455, a bill to amend the United States Energy Storage Competitiveness Act of 2007 to direct the Secretary of Energy to establish new goals for the Department of Energy relating to energy storage and to carry out certain demonstration projects relating to energy storage.

S. 1457

At the request of Mr. FLAKE, the name of the Senator from Idaho (Mr. CRAPO) was added as a cosponsor of S. 1457, a bill to amend the Energy Policy Act of 2005 to direct the Secretary of Energy to carry out demonstration projects relating to advanced nuclear reactor technologies to support domestic energy needs.

S. 1474

At the request of Ms. DUCKWORTH, the name of the Senator from Michigan (Mr. PETERS) was added as a cosponsor of S. 1474, a bill to prohibit the use of fiscal year 2018 funds for the closure, consolidation, or elimination of certain offices of the Environmental Protection Agency.

S. 1512

At the request of Mr. LANKFORD, the name of the Senator from Arkansas (Mr. COTTON) was added as a cosponsor of S. 1512, a bill to prohibit the Secretary of Energy, the Administrator of the Environmental Protection Agency, the Secretary of the Interior, the Secretary of Transportation, and the Chair of the Council on Environmental Quality from considering, in taking any action, the social cost of carbon, the social cost of methane, the social cost of nitrous oxide, or the social cost of any other greenhouse gas, unless compliant with Office of Management and Budget guidance, and for other purposes.

S. 1547

At the request of Mr. BOOKER, the name of the Senator from Colorado (Mr. BENNET) was added as a cosponsor of S. 1547, a bill to nullify the effect of the recent Executive order that establishes an "election integrity" commission, which will be used and is designed to support policies that will suppress the vote in minority and poor communities across the United States.

S. 1564

At the request of Ms. WARREN, the name of the Senator from New Jersey

(Mr. MENENDEZ) was added as a cosponsor of S. 1564, a bill to amend the Internal Revenue Code of 1986 to permit legally married same-sex couples to amend their filing status for returns outside the 3-year limitation.

S. RES. 114

At the request of Mr. YOUNG, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of S. Res. 114, a resolution expressing the sense of the Senate on humanitarian crises in Nigeria, Somalia, South Sudan, and Yemen.

S. RES. 139

At the request of Mr. WYDEN, the names of the Senator from New Mexico (Mr. HEINRICH) and the Senator from Delaware (Mr. COONS) were added as cosponsors of S. Res. 139, a resolution condemning the Government of Iran's state-sponsored persecution of its Baha'i minority and its continued violation of the International Covenants on Human Rights.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. CORNYN (for himself, Mr. BOOZMAN, Mr. CASSIDY, and Mr. RUBIO):

S. 1574. A bill to impose sanctions on individuals who are complicit in human rights abuses committed against nationals of Vietnam or their family members, and for other purposes; to the Committee on Foreign Relations.

Mr. CORNYN. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 1574

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Vietnam Human Rights Sanctions Act of 2017".

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The relationship between the United States and the Socialist Republic of Vietnam has grown substantially since the end of the trade embargo in 1994, with annual trade between the countries reaching more than \$36,000,000,000 in 2014.

(2) However, the transition by the Government of Vietnam toward greater economic activity and trade, which has led to increased bilateral engagement between the United States and Vietnam, has not been matched by greater political freedom or substantial improvements in basic human rights for the people of Vietnam.

(3) Vietnam remains an authoritarian state ruled by the Communist Party of Vietnam, which continues to deny the right of the people of Vietnam to participate in free and fair elections.

(4) According to the Department of State's 2014 Country Reports on Human Rights Practices, Vietnam's "most significant human rights problems . . . were severe government restrictions of citizens' political rights, particularly their right to change their government through free and fair elections; limits

on citizens' civil liberties, including freedom of assembly and expression; and inadequate protection of citizens' due process rights, including protection against arbitrary detention".

(5) The Country Reports also state that the Government of Vietnam "continued to restrict speech that criticized individual government leaders; promoted political pluralism or multi-party democracy; or questioned policies on sensitive matters, such as human rights, religious freedom, or sovereignty disputes with China" and "sought to impede criticism by monitoring meetings and communications of political activists".

(6) Furthermore, the Department of State documents that "arbitrary arrest and detention, particularly for political activists, remained a problem", with the Government of Vietnam sentencing 29 arrested activists during 2014. Of those, 6 activists were convicted on national security charges in the penal code for "undermining the unity policy", 17 for "causing public disorder", and 6 for "abusing democratic freedoms".

(7) At the end of 2014, the Government of Vietnam reportedly held more than 125 political prisoners.

(8) On September 24, 2012, 3 prominent Vietnamese bloggers—Nguyen Van Hai (also known as Dieu Cay), Ta Phong Tan, and Phan Thanh Hai (also known as Anh Ba Saigon)—were sentenced to prison based on 3-year-old blog postings criticizing the Government and leaders of Vietnam and the Communist Party of Vietnam. Nguyen Van Hai served 2 years of a 12-year prison sentence on charges of "conducting propaganda against the state" but was later released and departed from Vietnam. If he were to return, he would likely have to complete his prison sentence.

(9) United Nations High Commissioner for Human Rights Navi Pillay responded to the sentencing of the bloggers on September 25, 2012, stating that "[t]he harsh prison terms handed down to bloggers exemplify the severe restrictions on freedom of expression in Vietnam" and calling the sentences an "unfortunate development that undermines the commitments Vietnam has made internationally . . . to protect and promote the right to freedom of expression".

(10) On March 21, 2013, Deputy Assistant Secretary of State for Democracy, Human Rights, and Labor Daniel B. Baer testified before the Subcommittee on East Asian and Pacific Affairs of the Committee on Foreign Relations of the Senate that "in Vietnam we've been disappointed in recent years to see backsliding, particularly on . . . freedom of expression issues . . . people are being prosecuted for what they say online under really draconian national security laws . . . that is an issue that we continue to raise, both in our human rights dialogue with the Vietnamese as well as in other bilateral engagements".

(11) Although the Constitution of Vietnam provides for freedom of religion, the Department of State's 2013 International Religious Freedom Report maintains, "Government practices and bureaucratic impediments restricted religious freedom. Unregistered and unrecognized religious groups were often subject to harassment, as well as coercive and punitive actions by authorities".

(12) Likewise, the United States Commission on International Religious Freedom 2015 Annual Report states, "The Vietnamese government continues to control all religious activities through law and administrative oversight, restrict severely independent religious practice, and repress individuals and religious groups it views as challenging its authority, including independent Buddhists, Hoa Hao, Cao Dai, Catholics, and Protestants."

(13) The 2013 Annual Report notes that in 2004 the United States designated Vietnam as a country of particular concern for religious freedom pursuant to section 402(b)(1) of the International Religious Freedom Act of 1998 (22 U.S.C. 6442(b)(1)), and that Vietnam responded at that time by releasing prisoners, prohibiting the policy of forced renunciations of faith, and expanding protections for religious groups, and that "[m]ost religious leaders in Vietnam attributed these positive changes to the [country of particular concern] designation and the priority placed on religious freedom concerns in U.S.-Vietnamese bilateral relations".

(14) However, the 2013 Annual Report concludes that since the designation as a country of particular concern was lifted from Vietnam in 2006, "religious freedom conditions in Vietnam remain mixed", and therefore recommends to the Department of State that Vietnam should be redesignated as a country of particular concern.

(15) Deputy Assistant Secretary of State Baer likewise testified that "[i]n Vietnam the right to religious freedom, which seemed to be improving several years ago, has been stagnant for several years".

SEC. 3. IMPOSITION OF SANCTIONS ON CERTAIN INDIVIDUALS WHO ARE COMPLICIT IN HUMAN RIGHTS ABUSES COMMITTED AGAINST NATIONALS OF VIETNAM OR THEIR FAMILY MEMBERS.

(a) DEFINITIONS.—In this section:

(1) ADMITTED; ALIEN; IMMIGRATION LAWS; NATIONAL.—The terms "admitted", "alien", "immigration laws", and "national" have the meanings given those terms in section 101 of the Immigration and Nationality Act (8 U.S.C. 1101).

(2) APPROPRIATE CONGRESSIONAL COMMITTEES.—The term "appropriate congressional committees" means—

(A) the Committee on Finance, the Committee on Banking, Housing, and Urban Affairs, and the Committee on Foreign Relations of the Senate; and

(B) the Committee on Ways and Means, the Committee on Financial Services, and the Committee on Foreign Affairs of the House of Representatives.

(3) CONVENTION AGAINST TORTURE.—The term "Convention against Torture" means the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, done at New York on December 10, 1984.

(4) UNITED STATES PERSON.—The term "United States person" means—

(A) a United States citizen or an alien lawfully admitted for permanent residence to the United States; or

(B) an entity organized under the laws of the United States or of any jurisdiction within the United States, including a foreign branch of such an entity.

(b) IMPOSITION OF SANCTIONS.—Except as provided in subsections (e) and (f), the President shall impose the sanctions described in subsection (d) with respect to each individual on the list required by subsection (c)(1).

(c) LIST OF INDIVIDUALS WHO ARE COMPLICIT IN CERTAIN HUMAN RIGHTS ABUSES.—

(1) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the President shall submit to the appropriate congressional committees a list of individuals who are nationals of Vietnam that the President determines are complicit in human rights abuses committed against nationals of Vietnam or their family members, regardless of whether such abuses occurred in Vietnam.

(2) UPDATES OF LIST.—The President shall submit to the appropriate congressional

committees an updated list under paragraph (1) as new information becomes available and not less frequently than annually.

(3) PUBLIC AVAILABILITY.—The list required by paragraph (1) shall be made available to the public and posted on the Web sites of the Department of the Treasury and the Department of State.

(4) CONSIDERATION OF DATA FROM OTHER COUNTRIES AND NONGOVERNMENTAL ORGANIZATIONS.—In preparing the list required by paragraph (1), the President shall consider data already obtained by other countries and nongovernmental organizations, including organizations in Vietnam, that monitor the human rights abuses of the Government of Vietnam.

(d) SANCTIONS.—

(1) PROHIBITION ON ENTRY AND ADMISSION TO THE UNITED STATES.—An individual on the list required by subsection (c)(1) may not—

(A) be admitted to, enter, or transit through the United States;

(B) receive any lawful immigration status in the United States under the immigration laws, including any relief under the Convention Against Torture; or

(C) file any application or petition to obtain such admission, entry, or status.

(2) FINANCIAL SANCTIONS.—The President shall block and prohibit all transactions in all property and interests in property of an individual on the list required by subsection (c)(1) if such property and interests in property are in the United States, come within the United States, or are or come within the possession or control of a United States person.

(e) EXCEPTIONS TO COMPLY WITH INTERNATIONAL AGREEMENTS.—The President may, by regulation, authorize exceptions to the imposition of sanctions under this section to permit the United States to comply with the Agreement regarding the Headquarters of the United Nations, signed at Lake Success June 26, 1947, and entered into force November 21, 1947, between the United Nations and the United States, and other applicable international agreements.

(f) WAIVER.—The President may waive the requirement to impose or maintain sanctions with respect to an individual under subsection (b) or the requirement to include an individual on the list required by subsection (c)(1) if the President—

(1) determines that such a waiver is in the national interest of the United States; and

(2) submits to the appropriate congressional committees a report describing the reasons for the determination.

(g) TERMINATION OF SANCTIONS.—The provisions of this section shall terminate on the date on which the President determines and certifies to the appropriate congressional committees that the Government of Vietnam has—

(1) unconditionally released all political prisoners;

(2) ceased its practices of violence, unlawful detention, torture, and abuse of nationals of Vietnam while those nationals are engaging in peaceful political activity; and

(3) conducted a transparent investigation into the killings, arrest, and abuse of peaceful political activists in Vietnam and prosecuted those responsible.

SEC. 4. SENSE OF CONGRESS ON DESIGNATION OF VIETNAM AS A COUNTRY OF PARTICULAR CONCERN WITH RESPECT TO RELIGIOUS FREEDOM.

It is the sense of Congress that—

(1) the relationship between the United States and Vietnam cannot progress while the record of the Government of Vietnam with respect to human rights and the rule of law continues to deteriorate;

(2) the designation of Vietnam as a country of particular concern for religious freedom

pursuant to section 402(b)(1) of the International Religious Freedom Act of 1998 (22 U.S.C. 6442(b)(1)) would be a powerful and effective tool in highlighting abuses of religious freedom in Vietnam and in encouraging improvement in the respect for human rights in Vietnam; and

(3) the Secretary of State should, in accordance with the recommendation of the United States Commission on International Religious Freedom, designate Vietnam as a country of particular concern for religious freedom.

AMENDMENTS SUBMITTED AND PROPOSED

SA 259. Mr. CARDIN submitted an amendment intended to be proposed by him to the bill S. 1519, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 259. Mr. CARDIN submitted an amendment intended to be proposed by him to the bill S. 1519, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle G of title X, add the following:

SEC. 1088. MODIFICATION TO THE HUBZONE PROGRAM.

Section 3(p)(4)(C) of the Small Business Act (15 U.S.C. 632(p)(4)(C)) is amended by striking “until the later of” and all that follows and inserting “for the 7-year period following the date on which the census tract or nonmetropolitan county ceased to be so qualified.”.

AUTHORITY FOR COMMITTEES TO MEET

Mr. ALEXANDER. Mr. President, I have 9 requests for committees to meet during today's session of the Senate. They have the approval of the Majority and Minority leaders.

Pursuant to rule XXVI, paragraph 5(a) of the Standing Rules of the Senate, the following committees are authorized to meet during today's session of the Senate:

COMMITTEE ON ARMED SERVICES

The Committee on Armed Services is authorized to meet during the session

of the Senate on Tuesday, July 18, 2017, at 9:30 a.m., in open session to consider a nomination.

COMMITTEE ON ARMED SERVICES

The Committee on Armed Services is authorized to meet during the session of the Senate on Tuesday, July 18, 2017, at 2:30 p.m., in open session to consider the nominations.

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

The Committee on Banking, Housing, and Urban Affairs is authorized to meet during the session of the Senate on Tuesday, July 18, 2017 at 10 a.m. to conduct a hearing to consider nominations.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

The Senate Committee on Energy and Natural Resources is authorized to meet during the session of the Senate in order to hold a hearing on Tuesday, July 18, 2017 at 10:30 a.m. in Room 366 of the Dirksen Senate Office Building in Washington, DC.

COMMITTEE ON FINANCE

The Committee on Finance is authorized to meet during the session of the Senate on Tuesday, July 18, 2017, at 9 a.m., in 215 Dirksen Senate Office Building, to conduct a hearing entitled “Comprehensive Tax Reform: Prospects and Challenges.”

COMMITTEE ON FINANCE

The Committee on Finance is authorized to meet during the session of the Senate on Tuesday, July 18, 2017, at 11 a.m., in 215 Dirksen Senate Office Building, to consider the nomination of David J. Kautter, of Virginia, to be an Assistant Secretary of the Treasury, vice Mark J. Mazur.

COMMITTEE ON FOREIGN RELATIONS

The Committee on Foreign Relations is authorized to meet during the session of the Senate on Tuesday, July 18, 2017 at 10 a.m., to hold a hearing entitled “Nominations.”

COMMITTEE ON INTELLIGENCE

The Senate Select Committee on Intelligence is authorized to meet during the session of the 115th Congress of the U.S. Senate on Tuesday, July 18, 2017 from 3:30 pm–5:00 pm, in room SH-219 of the Senate Hart Office Building to hold a Closed Member Briefing.

COMMITTEE ON MULTILATERAL INTERNATIONAL DEVELOPMENT, MULTILATERAL INSTITUTIONS, AND INTERNATIONAL ECONOMIC, ENERGY, AND ENVIRONMENT

The Committee on Foreign Relations Subcommittee on Multilateral International Development, Multilateral In-

stitutions, and International Economic, Energy, and Environmental policy be authorized to meet during the session of the Senate on Tuesday, July 18, 2017 at 2:30 p.m., to hold a hearing entitled “‘The Four Famines’: Root Causes and a Multilateral Action Plan.”

PRIVILEGES OF THE FLOOR

Ms. HEITKAMP. Mr. President, I ask unanimous consent that Myles Odermann, an intern in my office, be granted floor privileges for the duration of today's session of the Senate.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDERS FOR WEDNESDAY, JULY 19, 2017

Mr. McCONNELL. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:30 a.m., Wednesday, July 19; further, that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and morning business be closed; further, that following leader remarks, the Senate proceed to executive session and resume consideration of the Bush nomination; finally, that the time until the cloture vote on the Bush nomination be equally divided between the two leaders or their designees.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. McCONNELL. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that it stand adjourned under the previous order.

There being no objection, the Senate, at 6:19 p.m., adjourned until Wednesday, July 19, 2017, at 9:30 a.m.

CONFIRMATION

Executive nomination confirmed by the Senate July 18, 2017:

DEPARTMENT OF DEFENSE

PATRICK M. SHANAHAN, OF WASHINGTON, TO BE DEPUTY SECRETARY OF DEFENSE.